RCS
BNP PARIBAS GROUP
CREDIT | LOANS | INSURANCE

Temporary Disability Illness, Injury, Accident CLAIM FORM

ACCOUNT HOLDER / INSURED PERSONAL INFORMATION	
Surname	
Initials	
First Name	
Date of Birth	
ID number of Insured	
Account Number – Store card/credit card/loan	

CLAIMANT INFORMATION	
Surname	
Initials	
First Name	
ID number	
Relationship to main Insured	
Telephone number (mobile)	
Email address	

IMPORTANT DOCUMENTS WE REQUIRE TO PROCESS THE CLAIM

Certified ID of insured
Doctors note (proof of days off)
Certificate by Medical Practitioner – page 2 of claim form
Certificate by Employer – page 3 of claim form
Email documents to claims@rcsgroup.co.za with completed claim form

DECLARATION:

I, the claimant, hereby certify that all the information I have provided relative to this claim is true and correct. I authorise any hospital, clinic, doctor, or other individual to furnish RCS with any information in respect of the claim, including any copies of medical records, consultations, medical history, sickness or injuries the deceased have had with any institution. I have not withheld any information which could be material to the assessment of the claim.

Signature claimant _____ Date _____

Mutualpark, Jan Smuts Drive, Pinelands, Cape Town 7405
PO Box 111, Goodwood, 7459
Tel: +27 (0)21 597 4000
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TO BE COMPLETED BY CLAIMANT	
What is your present occupation?	
How long have you been in this occupation?	
Are you self-employed YES/NO	
NATURE OF ILLNESS/DISABILITY	
What is the nature of your illness or disability?	
How was it caused?	
On what date did you first become aware of your disability?	
On what date did the symptoms first appear?	
DEGREE OF ILLNESS/DISABILITY	
Does your disability allow you to work? YES/NO	
If not, please explain why	
If YES, please advise on what date you will return to work	
Has your health improved during the past twelve months? If so, please explain to what extent	
Has your health deteriorated over the past twelve months? If so, please explain to what extent	
Has your health remained the same over the past 12 months?	
Have you been employed during the past twelve months? If so, when did you work, what type of work was it and who was your employer?	
PARTICULARS OF DOCTORS & HOSPITALS	
What is the name and address of your regular doctor?	
Since when has he/she been your regular doctor?	
Give the names & address of all doctors/hospitals/clinics where you have received treatment for your illness/disability	
DETAILS OF OTHER DISABILITY BENEFITS	
Are you insured against disability with any other insurer, fund or statutory body? Answer YES or NO	
Have you, or are you expecting a lump sum payment as a result of your disability? Answer YES or NO	
Are you presently receiving periodic payments or expecting to receive such payments? Answer YES or NO	
If any of the answers above is YES, please state the source of the benefit, the date the benefit commenced and the amount of the benefit	

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CERTIFICATE BY MEDICAL PRACTITIONER - TO BE COMPLETED BY DOCTOR	
PATIENT INFORMATION	
Full name and surname of patient	
Identity number of patient	
Are you the patient's regular doctor? If YES since when	
If not, who is the patient's regular doctor?	
Date of last consultation	
ILLNESS/DISABILITY INFORMATION	
What is the direct cause of the disability?	
When was the condition first diagnosed?	
Was the patient informed of diagnosis. If so, please provide the date patient was first informed	
Are you aware of any illness or habit that may have given rise to present ailment?	
What contributing factors led to the disability? Please provide dates of diagnosis	
Please list consultations over the past five years with dates and particulars (consultation date, diagnosis, treatment, medication prescribed, prognosis)	
Name & address of specialists if referred & date referred	
PROGNOSIS	
What is the functional impairment caused by the condition?	
List the treatment and the response to treatment	
What is your opinion on the duration of the condition?	
If not already covered, what is the prognosis?	
On what date will the patient return to work?	

Signed at and Date	
Surname and initials of medical practitioner	
Signature of medical practitioner	
Telephone number and Practice number	
Practice address	
Qualifications of medical practitioner	

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CERTIFICATE BY EMPLOYER - TO BE COMPLETED BY YOUR EMPLOYER	
EMPLOYEE INFORMATION	
Full name and surname of employee	
Identity number of employee	
Current occupation	
Period of employment from and to	
Employee payroll number	
Name of Employee's medical scheme and number	
EXTRACT FROM SICK RECORDS	
Please provide sick records including: • Date range of each sick leave request • Reason for taking sick leave • Name of doctor, hospital, clinic • Address of doctor, hospital, clinic	
DETAILS OF DISABILITY	
For what period has the employee been booked off?	
Will the employee be returning to work? YES/NO	
If YES, on what date?	
Occupation before disability	
Is the employee still receiving full salary? YES/NO	
If YES will this change and if so, when?	
If NO, is the employee currently on unpaid leave?	
If not, please provide the reason	
Date last actively at work	
Is the employee still in your employment? YES/NO	
If YES, what is the present occupation?	

Signed at and Date	
Employer name	
Signature of authorized individual	
Address, email and contact number	

OFFICIAL STAMP & DATE

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PROCESSING OF PERSONAL INFORMATION IN TERMS OF POPI ACT 4 OF 2013

Your privacy is of utmost importance to Us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner and kept for the period prescribed by the Applicable Laws.

You hereby agree to give honest, accurate and up-to-date Personal Information which may be used for the following reasons:

- to establish and verify your identity in terms of the Applicable Laws;
- to enable Us to fulfil our obligations in terms of this Claim;
- to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share your information for further processing with the following third parties, which third parties have an obligation to keep your Personal Information secure and confidential:

- Payment processing service providers,
- merchants,
- banks and other persons that assist with the processing of any benefit payable;
- Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime;
- Regulatory authorities,
- industry ombudsmen,
- governmental departments,
- local and international tax authorities, and other persons that we, in accordance with the Applicable Laws, are required to share your Personal Information with; and
- Credit Bureau's.

You acknowledge that any Personal Information supplied to Us in terms of this Claim is provided according to the Applicable Laws. Unless consented to by yourself, we will not sell, exchange, transfer, rent or otherwise make available your Personal Information to any other parties and you indemnify Us from any claims resulting from disclosures made with your consent. Such Personal Information provided (voluntarily, unconditionally and specifically) will be utilized by Us or by any appointed third parties, on our behalf, and will be kept for such period as legislated according to the Applicable Laws.

You understand that if We have utilized your Personal Information contrary to the Applicable Laws, you have the right to lodge a complaint with Guardrisk within 10 (ten) days. Should Guardrisk not resolve the complaint to your satisfaction, you have the right to escalate the complaint to the Information Regulator.

Signature	
Date	

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