CLAIM FORM CREDIT LIFE: DISABILITY

GROUPS R US INSURANCE PARTNERS

Suite 09A, Monpark Building, 76 Skilpad Avenue, Monument Park, Pretoria, 0081 • Tel: 086 127 3342 • claims@groupsrus.co.za • www.groupsrus.co.za

Disability Claim

Section A: Details of Insured

Policy Number
Full Names & Surname
Date of Birth (D D M M Y Y Y Y) ID Number
Address
Code
Occupation
Employer
Employer's Phone

POPI Act Disclosure and Permission:

(1) In line with the Protection of Personal Information Act no. 4 of 2013 I hereby give consent that all personal information supplied herewith may be used for the sole purpose related to the document intent herewith.
(2) I further consent that the data be used or exchanged with 3rd parties to validate information, fraud prevention, investigations, payments processing and product related marketing campaigns. I provide consent for Groups Are Us (Pty) Ltd to share my information with the external compliance officers for quality control and risk mitigating matters.
(3) Section 18 of the FAIS Act requires that records like client transactions, complaints, cancellations and financial records be kept for five (5) years. I understand that I can exercise my right to opt-out and avoid or stop any further use of my personal data within this disclosure after the record keeping requirement period is over.
(4) I acknowledge and understand that I can make contact with the Information Officer of Groups Are Us (Pty) Ltd to lodge a complaint for any suspected abuse and/or regulatory misconduct around my personal information processing or if personal information is being used for any reasons outside the intent of this document.

Step 1: Complaints Process
Groups Are Us
Suite 9A
76 Skilpad Road
Monument Park
Pretoria
0181
Mail info@Groupsrus.co.za

Step 2: If complaint is not resolved
Information regulator
P.O Box 31533
Braamfontein
Johannesburg
2017
Mail complaints.IR@justice.gov.za

*For our Privacy Policy please refer or visit: www.groupsrus.co.za

Section B: Nominated Credit Provider Details

Credit Provider
Loan Agreement Account Number
Outstanding Balance R
Credit Provider Contact Person Name and Surname
Credit Provider Contact Person Contact Details

Credit Provider Bank Account Details

Credit Provider
Bank Account Number
Branch Code
Bank
Account Type

Section C and D: To be completed by Medical Practitioner

1) Diagnosis of patient's condition _____

2) The Cause of the patient's disability _____

3) Date of Diagnosis (D D M M Y Y Y Y)

4) Was the patient informed of the diagnosis? Yes No

5) Details of complications or concurrent conditions _____

a) Date of first consultation and treatment with regards to the patient's present medical condition (D D M M Y Y Y Y)
b) Date of last consultation and treatment with regards to the patient's present medical condition (D D M M Y Y Y Y)
c) Names, address and contact numbers of any other medical practitioners who may be consulted

Name
Address
Code

7) Full details of treatment from the date of first consultation to the current date, the results, and the reasons, if any, for change

8) Please provide details of other information, which may be useful to the company in assessing this claim etc

Mail completed form to claims@groupsrus.co.za

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9) Please provide us with copies of all investigations, laboratory tests,specialist reports etc.

IMPAIRMENT is the alteration of normal functional capacity, that is, which functions is the person still able to do and which not, due to disease, and in assessment by medical means, after a diagnosis has been established, and appropriate and optimal treatment applied.
DISABILITY is the alteration of capability to meet the personal, social or occupational demands due to impairment, and is judged by non-medical means, that is in conjunction with his job description, policy disability clause condition and personal factors, such as education, experience etc.

For ease of reference we have provided the definitions as accepted by the insurance market of impairment and disability and would request that you do not comment on the nature of the occupational disability unless the details of the policy definition have been made available to you and such a decision specifically requested. As this decision may interfere with your doctor-patient relationship it is in your own interest not to make such comments.

We require an objective medical opinion of the impairment experienced by your patient, providing full details of all limitations in movement, use or restriction.

The details of all treatment from the elementary to the most advanced will provide us with a full picture of the condition and it's progression.

Section D: Declaration

Name
Tel
Address

Qualifications
Practice Number
Code

Doctor's Signature _____

Date D D M M Y Y Y Y

Section E: Supporting Documentation Required

	Office Use Only	
Disability Claim Form	Y	N
Copy of Loan Contract	Y	N
Copy of Support 4 U Policy Certificate	Y	N
Client/Borrower Statement from your Loan Management System	Y	N
Copy of Policy Holder's Identity Document	Y	N
Medical Report(s) from the physician relevant to the Disability being claimed for	Y	N
Ensure that the relevant claim form is completed by the attending physician	Y	N

_____
Claimant Signature

_____
Date of Application

_____
Claim Processor: Name and Signature

_____
Date: Finalised

_____
Claim Supervisor: Name and Signature

_____
Date: Finalised

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