ambledown FINANCIAL SERVICES (PTY) LTD

Ambledown is an Authorised Financial Services Provider, No. 10287

ORIGIN

GUARDRISK TAILORED RISK SOLUTIONS

Guardrisk Insurance Company Limited,
a licensed non-life Insurer and an authorised financial services provider (No.75)

ORIGIN GAP COVER SERIES

Premium Waiver Claim Form

Underwritten by Guardrisk Insurance Company Limited (GICL), a licensed Non-Life insurer and an authorised Financial Services provider, Reg. No. 1992/001639/06 , FSP No. 75

This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership. The master policy issued is the source of all benefits, rights, and obligations and exclusions. To determine your individual needs, we suggest you contact your broker and request advice from him/her.

Claiming Procedures

Claims should be submitted in writing by no later than one hundred and eighty (180) days/six months (6) from the first day of treatment *(i.e. complete the claim form as soon as possible).*

BEFORE ANY CLAIM CAN BE SETTLED, COPIES OF THE FOLLOWING DOCUMENTATION RELATING TO THIS PARTICULAR CLAIM/S ARE REQUIRED:

1. Original death certificate where possible (if claiming for death)
2. Medical Report confirming Total and Permanent Disability (if claiming for disability)
3. Medical Scheme Certificate of Membership
4. Certified copies of ID documents

Ambledown Financial Services (Pty) Ltd
PO Box 1862, Cramerview, 2060
Tel: 086 126 2533
Fax: 011 463 1665
Email: claims@ambledown.co.za

You can download the g-App on your mobile phone to submit and track your claim, quickly and easily.

(Failure to provide all applicable documentation to this claim form will cause undue delay in the processing thereof)

Principal Insured Member Details

* *FICA Requirements*

Title: Surname:

ID / passport number: * First names:

Date of birth: D D M M Y Y Y Y

Policy / Member number:

Contact Details

* *FICA Requirements*

Postal address

Postal code:

* Physical address *(if different to postal)*

Postal code:

Home number:

* Cell number:

Employer contact number:

Employer:

* Email:

Details of Claim

Surname: First names:

ID / Passport number: Relationship to main member:

Date of birth:

Cause of death / total and permanent disability

State exact cause of death / total and permanent disability:

Date of incident: D D M M Y Y Y Y

Claimant or Beneficiary Details

Surname: Initials:

ID / Passport number:

Date of birth: D D M M Y Y Y Y

Relationship to principal insured:

Contact Details

Home number: Cell number:

Email:

Payment Instructions

Should benefits be paid into the bank account from which your policy premiums are collected? Yes ☐ No ☐

Benefits to be paid into the following bank account by means of electronic fund transfer:

Account holder's name: Bank / Building Society:

Account number: Branch:

Branch code: Account type ☐ Current

Source of funds: *(No credit card accounts accepted)* ☐ Transmission ☐ Savings

The company will not be liable for the loss of funds due to the provision of incorrect bank details by the member.

Premium Waiver Benefit Claim

The following documents must accompany this claim form – which must be fully completed. (tick the boxes below accordingly)

1.	Original death certificate where possible (if claiming for death).	☐
2.	Medical Report confirming Total and Permanent Disability (if claiming for disability).	☐
3.	Medical Scheme Certificate of Membership.	☐
4.	Certified copies of ID documents.	☐

Declaration

I hereby declare that the person mentioned under claim details is nominated under the above-mentioned policy, that all the particulars given are true and complete, and that his / her / my incapacitating condition was not wholly or partly, directly or indirectly caused by the contingencies mention in the exclusions of the policy in question.

I further declare that the above statements and answers to the questions under the relevant sections are true and completed in full, that I/ we have not withheld any material information and that I/we undertake to furnish any documentation which may be required by the Insurer. I expressly waive all provisions of law, custom or professional etiquette forbidding any physician or any other person attended or examined the deceased or any institution in which the deceased received treatment to disclose any knowledge or information which was thereby acquired and I/we authorise all such persons or agencies to furnish any information in their possession to the Insurer or its authorised representative.

I hereby authorise any hospital, physician or other person who has attended or examined the deceased to furnish to Ambledown, Constantia Life & Health Assurance Company Limited or its authorised representative any information with respect to any illness or injury medical history consultation prescriptions or treatment and copies of all hospital or medical records.

I consent to Ambledown or its authorised representatives from obtaining and processing my and the deceased's personal information and I understand why my /their personal information is required and the purpose it will be used.

I acknowledge I have the right to request from Ambledown details of any of my personal information Ambledown holds on my behalf and details of how my personal information has been processed and to lodge a complaint with the Information Regulator.

SIGNATURE OF INSURED PERSON | PRINTED NAME OF INSURED PERSON | DATE D D M M Y Y Y Y

Please return to your broker or alternatively:

Ambledown Financial Services (Pty) Ltd, PO Box 1862, Cramerview, 2060

Tel Number 0861 262533, Fax Number 011 463 1600, E-mail Address: claims@ambledown.co.za

Brokerage: _____ FSP number: _____

Tel number: _____ Email address: _____