proud2b@triarc.co.za | www.triarc.co.za
Phone: 087 231 0222 | Fax: 086 235 5238
Unit 122 The Quays, Park Lane
Century City, 7441
TRIARC is an authorised financial services provider FSP45009

DREAD DISEASE CLAIM

Please complete form in block letters

Important

- An accurately completed form is essential in order to avoid delays in the assessment process. A claim can be considered only if all required documents and all the supplementary statements (as indicated below) have been completed in full and are in Triarc's possession.
- It is also important that you should be aware of the implications of the non-payment/payment of this claim for your financial position. We therefore strongly recommend that at this stage that you should already contact Triarc to assist you in this regard.
- This form and all relevant documents can be sent to us by e-mail or by post. If legible copies of documents are provided to us, the original documents will not be required.
  Please note: A claim can only be submitted for the claim events as stipulated in the contract, on all the above-mentioned benefits.

Section 1. Particulars of Policyholder

Surname			
First Name(s)			
ID Number			
Date of Birth	Y Y Y Y M M D D	Gender	F M
		Title	
Passport No.		Date of Expiry	Y Y Y Y M M D D
Country of Issue			
Maiden Name			
Telephone Number			
Cellphone			
Email Address			

Marital Status: Single ☐ Married ☐ Divorced ☐ Other ☐

Residential address

Suite/ unit number		Complex Name	
Street Number		Street Name	
Suburb		City	
Region		Postal Code	

Section 2. Nature of Claim and Particulars of Consultations

Stipulate the illness you are claiming for.

Describe the symptoms you are experiencing and state the date the symptoms began.

Diagnosis being claimed for.

Date of Diagnosis | Y | Y | Y | Y | M | M | D | D |

Date of first symptoms | Y | Y | Y | Y | M | M | D | D |

Have you suffered from this illness/impairment previously? Yes ☐ No ☐

If “Yes”, please supply details (e.g. Date diagnosed, treatment received, name of treating doctor, etc.):

Have you previously received any benefit from any life insurance company? Yes ☐ No ☐

If “Yes”, please supply details (e.g. Type of benefit, when received, name of insurer, etc.):

Details of Doctors, Specialists & Consultations you have had regarding the condition you are claiming for.

Name and Surname	Type of Specialist	Telephone No.	First Consultation

If this is NOT your Family Doctor, state the initials, surname, telephone number and address of this Doctor who referred you to the Specialist(s) mentioned above.

Telephone Number

Section 3. Medical History

State the initials, surname, address, and telephone number of:

Present Family Doctor

Telephone Number

Since when have you been consulting your present Family Doctor? Y Y Y Y M M D D

On what date did you last consult your present Family Doctor Y Y Y Y M M D D

Previous Family Doctor

Telephone Number

Section 4. Other Dread Disease Insurance

Dread disease insurance at other insurers

Name of Insurer	Policy Number	Sum Insured
		R
		R
		R
		R

Section 5. Payments

Please note that the premium payments must be continued until a claim, if any, has been approved.

Provide us with a copy of your bank statement (not older than three months) on a bank letterhead which indicates the Account Number and Account Holder's name. If the claim of the Life Insured is approved, Triarc is able to make the money available by means of an Electronic Funds

Account holder Name

Bank Name

Branch Name Branch Code

Account Number

Account Type ☐ Cheque ☐ Transmission ☐ Savings

I the undersigned, hereby declare that the above information is true and correct and confirm that Triarc will not be held liable for any loss that may arise from the use of this information.

Signature of Authorised Person Date Y Y Y Y M M D D

Section 6. Declaration

I declare that the particulars contained in this form are true and correct. I also irrevocably authorize any Person or institution, Medical Practitioner, Medical Specialist, Hospital, Nursing Institution or Medical Authority to provide Triarc with any information that may be required regarding my health. Further, I irrevocably authorize Triarc to share t-with other insurers that information and any information contained in this proposal or any related plan or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Triarc or by the database operators.

Signature of Authorised Person Date Y Y Y Y M M D D

Annexure A – Supporting Documents

The following supporting documentation must be submitted:

Policyholder	
Certified Copy (by a Commissioner of Oaths) of your Identity document or back and front copies of the Identity card	
Completed Claim Form	
Completed Medical Report by treating Specialist	