TRIARC
GUARDRISK TAILORED RISK SOLUTIONS
employeebenefits@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

Group Risk Disability Cover Benefit Claim Form - Certificate of Continued Disability

How to complete this form

This form must be completed in full by the member (if he/she is unable to do so, the legal representative or power of attorney should do so). On completion, this form must be sent to Triarc. Should you have any queries or need advice, please contact Triarc Group Risk on 087 231 0222 or employeebenefits@triarc.co.za.

1. Scheme Details

Scheme Name

Policy Number

Employer Name

Designation

Office Telephone Number

2. Details of Member

Surname

First Names

Date of Birth

Y Y Y Y M M D D

ID Number

Country of Origin

Residential Address

Code

E-mail Address

Telephone Number

Cellphone Number

Triarc is an authorised Financial Services Provider FSP45009. Triarc Insurance Products are underwritten by Guardrisk Life Limited, a licensed life insurer with FSP76

3. Current Medical Status

Please describe your current health problems

Please describe the functional difficulties you experience in activities of daily living

Please give us the dates, names and contact details of all doctors, specialists, hospitals or clinics you consulted about your medical condition over the past 12 months

(include hospital or clinic reference numbers)

Doctor / Specialist / Hospital

Date Y Y Y Y M M D D

Contact Number

Other Information

Doctor / Specialist / Hospital

Date Y Y Y Y M M D D

Contact Number

Other Information

Doctor / Specialist / Hospital

Date Y Y Y Y M M D D

Contact Number

Other Information

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3. Current Medical Status (Continued)

Doctor / Specialist / Hospital

Date Y Y Y Y M M D D

Contact Number

Other Information

Doctor / Specialist / Hospital

Date Y Y Y Y M M D D

Contact Number

Other Information

Doctor / Specialist / Hospital

Date Y Y Y Y M M D D

Contact Number

Other Information

Have you been hospitalized due to your medical condition over the past 12 months? ☐ Yes ☐ No

If Yes, Please Supply

Name of Hospital

Date of Admission Y Y Y Y M M D D

Hospital Number

Date of Discharge Y Y Y Y M M D D

Please give the details of the treatment you received (medical and surgical) over the past 12 months

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3. Current Medical Status (Continued)

In your opinion, has your condition improved, regressed or stayed the same? Please give details

4. Income Details

Are you working at the moment?	☐ Yes	☐ No

If Yes, please provide details of your duties, hours you work and your salary:

If No, when do you expect to return to work?

Do you do odd jobs for remuneration although not officially employed?	☐ Yes	☐ No

If Yes, please provide details of your duties, hours you work and your salary:

Are you involved in activities that (under normal circumstances) may generate an income?	☐ Yes	☐ No

If Yes, please provide details:

Have you attempted to earn an income or find alternative work?	☐ Yes	☐ No

If Yes, please provide details:

Are you receiving any income from another occupation or business venture?	☐ Yes	☐ No

If Yes, please provide details:

4. Income Details (Continued)

If you have claimed and/or expect to receive any benefit, income or pension for this period, from any other employer, insurance company, pension/provident fund or from any other source, please specify:

Source of Benefit		
Amount	**Type**	**Payment Date/Commencement**
R	Lump Sum / Recurring Payment	Y Y Y Y M M D D

Source of Benefit		
Amount	**Type**	**Payment Date/Commencement**
R	Lump Sum / Recurring Payment	Y Y Y Y M M D D

Source of Benefit		
Amount	**Type**	**Payment Date/Commencement**
R	Lump Sum / Recurring Payment	Y Y Y Y M M D D

Source of Benefit		
Amount	**Type**	**Payment Date/Commencement**
R	Lump Sum / Recurring Payment	Y Y Y Y M M D D

Source of Benefit		
Amount	**Type**	**Payment Date/Commencement**
R	Lump Sum / Recurring Payment	Y Y Y Y M M D D

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R	Lump Sum / Recurring Payment	Y Y Y Y M M D D

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5. Declaration

I hereby make a claim to the benefits of the above assurance contract/s and declare the following:

The answers and statements I have made are true, correct and I have withheld no material fact from Triarc. I agree the written statements and affidavits submitted in support of this claim shall constitute part of this claim. I agree that benefits payable in respect of this claim shall be forfeited if I, or any person acting on my behalf with my consent, have withheld any material fact or submitted any false information for this claim. I authorise any person, possessing any information relating to income, illness or injury, to give Triarc or its representatives such information where it may be necessary for Triarc's consideration of the continuance of the disability benefits.

Signed at

Date

Y Y Y Y M M D D

Member Name

Member Surname

Witness Name

Witness Surname

Member Signature

Witness Signature

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6. POPIA Consent Clause - Claim Forms

Processing of Personal Information in terms of the Protection of Personal Information 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:

1. to establish and verify your identity in terms of the Applicable Laws;
2. to enable Us to fulfil our obligations in terms of this Claim;
3. to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
4. 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:

1. Payment processing service providers, merchants, banks and other persons that assist with the processing of any benefit payable;
2. Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime;
3. 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
4. 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 utilised 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 utilised 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.

Signed at

Date

Y Y Y Y M M D D

Signatory First Name(s) and Surname

Signature