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 Dread Disease Cover Benefit Claim Form - Employer/ Employee Declaration

How to complete this form

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

This declaration will form the basis on which the claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Distortion of information could be used as a basis for the claim being declined.

Please attach the following:

- Copy of payslip as at date of diagnosis
- A copy of member's ID/passport

We will also require the Dread Disease Confidential Medical Report and copies of all relevant clinical investigation findings in order to assess this claim.

Completed form together with supporting documents to be faxed to 086 235 5238 or emailed to employeebenefits@triarc.co.za.

1. Scheme Details

Scheme Name

Policy Number

Postal Address

Code

Contact Person

Designation

Office Telephone Number

E-mail Address

2. Details of Member

Surname

First Names

Initials

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

Company/Employee Number

Medical Aid Name

Medical Aid Number

Date of Employment (Y Y Y Y M M D D)

When did the member first become eligible for membership of the plan?

Date of Eligibility (Y Y Y Y M M D D)

Salary per Annum

R

3. Current Medical Status

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

When did you see a doctor about your current illness/impairment for the first time? Y Y Y Y M M D D

Please supply name and contact details of the Doctor consulted:

Name and Surname of Doctor

Physical Address

Code

Telephone Number

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

If Yes, please supply details (eg. 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 (eg. Type of benefit, when received, name of insurer, etc.):

Please give name, address and telephone number of your regular family Doctor/General Practitioner

Name and Surname of Doctor

Physical Address

Code

Telephone Number

3. Current Medical Status (Continued)

Since when has he/she been you family Doctor?	Y	Y	Y	Y	M	M	D	D

When was the last consultation?	Y	Y	Y	Y	M	M	D	D

If you have changed General Practitioners in the last two years, please give details of all previous attending practitioners.

Name and Surname of Doctor

Telephone Number | **Patient Number**

Physical Address

Code

Date of First Consultation							
Y	Y	Y	Y	M	M	D	D

Date of Last Consultation							
Y	Y	Y	Y	M	M	D	D

Name and Surname of Doctor

Telephone Number | **Patient Number**

Physical Address

Code

Date of First Consultation							
Y	Y	Y	Y	M	M	D	D

Date of Last Consultation							
Y	Y	Y	Y	M	M	D	D

Name and Surname of Doctor

Telephone Number | **Patient Number**

Physical Address

Code

Date of First Consultation							
Y	Y	Y	Y	M	M	D	D

Date of Last Consultation							
Y	Y	Y	Y	M	M	D	D

3. Current Medical Status (Continued)

Please give the names and contact details of all medical practitioners consulted in connection with you current illness/impairment.

Doctor / Specialist / Hospital

Speciality

Condition Treated

Consultation Date Y Y Y Y M M D D

Telephone Number

Physical Address

Code

Doctor / Specialist / Hospital

Speciality

Condition Treated

Consultation Date Y Y Y Y M M D D

Telephone Number

Physical Address

Code

Doctor / Specialist / Hospital

Speciality

Condition Treated

Consultation Date Y Y Y Y M M D D

Telephone Number

Physical Address

Code

3. Current Medical Status (Continued)

Please give the names and contact details of all medical practitioners consulted in connection with you current illness/impairment. (Continued)

Doctor / Specialist / Hospital

Speciality

Condition Treated

Consultation Date

Y Y Y Y M M D D

Telephone Number

Physical Address

Code

Doctor / Specialist / Hospital

Speciality

Condition Treated

Consultation Date

Y Y Y Y M M D D

Telephone Number

Physical Address

Code

Doctor / Specialist / Hospital

Speciality

Condition Treated

Consultation Date

Y Y Y Y M M D D

Telephone Number

Physical Address

Code

3. Current Medical Status (Continued)

Details of any hospitalisations within the last five years.

Hospital

Reason for Admission

Surgery Preformed

Date of Admission Y Y Y Y M M D D

Date of Discharge Y Y Y Y M M D D

Hospital

Reason for Admission

Surgery Preformed

Date of Admission Y Y Y Y M M D D

Date of Discharge Y Y Y Y M M D D

Hospital

Reason for Admission

Surgery Preformed

Date of Admission Y Y Y Y M M D D

Date of Discharge Y Y Y Y M M D D

Hospital

Reason for Admission

Surgery Preformed

Date of Admission Y Y Y Y M M D D

Date of Discharge Y Y Y Y M M D D

4. Banking Details (for payment of benefit)

Payment of the Dread Disease benefit - We instruct Triarc to pay the Dread Disease benefit by Electronic Funds Transfer (EFT) as detailed here:

1. To ensure fast payment and for your protection, payment will only be made by Electronic Funds Transfer
2. Payment will only be made to the policy owner or nominated beneficiary
3. No payment to a third party will be allowed
4. We will require proof of the account (cancelled cheque or bank statement with account number and name of accountholder)

Please ensure the account information is correct. Triarc will not be held responsible for delays or other damages because of incorrect details being provided. If payment is required to more than than one account, please provide proof of all account details. No payments can be made to a non-South African bank.

Account holder

Name of Bank

Branch Code

Account Type

Current | Transmission | Savings

Account Number

5. Declaration of Employer

I hereby declare that all particulars furnished in this form and accompanying documents are true and correct and that no material information has been withheld or omitted. I authorise Triarc to disclose this information to any other party whose opinion is required for the assessment of the claim.

Signed at

Date

Y Y Y Y M M D D

Signatory First Name(s) and Surname

Designation

Signature

Company Stamp

6. Declaration of Member

Declaration

I declare that to the best of my knowledge all the particulars given on this claim form are true and correct, and that no material information has been withheld or omitted. I understand that any false and/or misrepresentation of information could be used as a basis for the claim being declined.

Consent to collect and share personal and health information
I hereby consent and authorise:

- Any health practitioner (e.g. medical practitioner, dentist, occupational therapist, psychologist, etc.), allied health practitioner, hospital, medical aid, employer, insurance company, health risk management service provider appointed by my employer or any other person who has information about my health, employment related activities and personal information, to provide such information to Triarc (Pty) Ltd or any 3rd party nominated by Triarc (Pty) Ltd who requires this information for the purposes of assessing my claim.
- Triarc to furnish any medical, occupational and personal information contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, to a health practitioner, allied health practitioner, health risk management service provider appointed by my employer, or any 3rd party nominated by Triarc who may require such information for the purpose of assisting Triarc in the assessment of my claim or for assessing the payment of a benefit provided for in a risk policy where I am the policyholder.
- Triarc to furnish my employer or its duly appointed intermediary with regular claim status reports which will contain personal information but not any health related information unless I have given my express consent for this information to be provided.

Signed at	Date
	Y Y Y Y M M D D

Name and Surname

Member Signature

7. POPIA Consent Clause - Employer - Disability

Processing of Personal Information in terms of the Protection of Personal Information Act 4 of 2013

The privacy of our Insured 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.

The Insured's Personal Information will be used to assess this disability claim for the Insured.

You hereby agree to give honest, accurate and up-to-date Personal Information of our Insured to assist us in assessing the risk insured against.

You acknowledge that any Personal Information supplied to us in respect of the Insured is provided according to the Applicable Laws.

Unless consented to by yourself, we will not sell, exchange, transfer, rent or otherwise make available any Personal Information you have provided in respect of our Insured unless it is a requirement in terms of the Applicable Laws.

Signed at	Date
	Y Y Y Y M M D D

Signatory First Name(s) and Surname

Signature