DISABILITY CLAIM FORM

Real People Assurance Company Limited is a registered Financial Services Provider (FSP 26634)
Reg. No. 2001/028918/06 | Real People Views | 12 Esplanade Road | Quigney | East London | 5201
P.O. Box 19610 | Tecoma | 5214

for REAL PEOPLE®

SUBMISSION OF CREDIT LIFE CLAIMS: FACSIMILE 086 623 4234 | HELPDESK: 086 111 4803 | E-MAIL: rpcreditlife@realpeople.co.za
SUBMISSION OF CLAIMS FOR OTHER POLICIES: HELPDESK 086 111 4803 | FAX TO 086 623 4080 | E-MAIL realinsuranceclaims@realpeople.co.za

A. HOW TO FILL IN THE APPLICATION FORM

1. Complete the form in black ink and in block letters.
2. Submit the form to Real People Assurance Company Limited ("RP Assurance") using the above contact details.
3. To assess the claim fully, the following documents are required.

CHECKLIST FOR SUBMISSION

3.1. A certified copy of Identity Document of claimant. ☐

3.2. Medical certificate for disability claim form completed by the relevant medical practitioner. ☐

3.3. Employer's declaration for disability form completed by employer. ☐

3.4. Board / Medical certificate on doctor's letterhead. ☐

3.5. Proof of banking of Credit Provider, for example a bank statement with the original bank stamp (to be supplied with a Credit Life Claim). ☐

4. RP Assurance will contact you once we have assessed the claim. Depending on the circumstances, there may be other requirements over and above those listed in this document. Please make sure that you complete this form in full and meet all the requirements set out in this form to prevent hold up of claim payment.

B. PERSONAL STATEMENT BY THE LIFE ASSURED (TO BE FULLY COMPLETED IN ALL INSTANCES)

Policy number

Names

Surname

Date of Birth D D M M Y Y ID number

Physical Address

Area Code

Postal Address

Postal Code

Home No. Work No.

Cell No. Fax No.

E-mail address

Occupation

Name of last Employer

Contact Person at Work

C. DETAILS OF CONTACT PERSON FOR THIS CLAIM – ONLY TO BE COMPLETED IF DIFFERENT FROM THE LIFE ASSURED

Names

Surname

Relationship to Life Assured

Physical Address

Area Code

Postal Address

Postal Code

Home No. Work No.

Cell No. Fax No.

E-mail address

In the event that the life assured is incapable of managing his/her own affairs, an appointment of a curator bonis will be required in order for RP Assurance to further assess the claim.

Please note that in the event of any modification or variation of this standard form Real People Assurance Company will regard this form as being invalid and of no force and effect.

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Your taxable income for the last tax year

Have you or the Owner / Life Assured ever been involved or are any sequestration hearing proceeding, pending or contemplated? Yes No

If "yes", please provide details

Are you a smoker? Yes No

If "yes", how many per day?

Do you consume alcohol? Yes No

If "yes", what do you drink and the quantity consumed?

D. INFORMATION RELATING TO YOUR MEDICAL CONDITION

Nature of medical condition

Indicate if your impairment(s) / disability are due to Accident/Trauma Disease/Illness

If the medical condition resulted from an accident, when, where and how did the accident occur?

Police station where accident was reported?

Case number

Have you instituted any claim for benefits against the Road Accident Fund? Yes No

If "yes", please provide us with a reference number under which the claim was lodged

If medical condition is due to illness or disease, please state date diagnosed

D	D	M	M	Y	Y	Y	Y

Please give date of consultations and provide full details of medical practitioners consulted

Doctor's name	Telephone number	Reason for consultation	Date of consultation

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What prescribed treatment are you currently taking / using?

Details of your usual doctor during the last 5 years

Name and Surname	
Phone number	
Address	

E. PARTICULARS OF PRESENT OCCUPATION (ALSO APPLICABLE TO SELF-EMPLOYED)

Name of Employer	
Address	
Employee number	

Start of service with employer: D D M M Y Y Y Y

What was your full-time occupation immediatly before your current disability / impairment began?

Breakdown of your duties

	Administrative %	Supervisory %	Manual %	Travel %
Current				
Previous				

Give an accurate description of the exact duties and nature of your full time occupation (job description)

How long have you been following this occupation?

On what date were you last able to undertake any part of the duties of your occupation?

D D M M Y Y Y Y

When do you expect to return to work?

D D M M Y Y Y Y

State particulars of other occupations?

Have you been offered, or enquired about, any alternative occupation for remuneration by your employer? Yes No

If “yes”, describe duties of alternative occupation offered

Have you accepted the alternative occupation offered? Yes No

If “yes”, when do you expect to start following alternative occupation

On full time basis	D	D	M	M	Y	Y	Y	Y
On part time basis	D	D	M	M	Y	Y	Y	Y

What is your expected remuneration?

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Occupations held in the past

Nature of occupation	Employer	Start date	End date

Did you receive any benefits from your employer? Yes No

If "yes", please state details _____

F. INFORMATION RELATING TO YOUR INCOME

What was your taxable income for the past 12 months? _____

Have you received any income since disablement? Yes No

If "yes", please state income for every month since disablement, including amounts, dates and source of income

Income amount	Date	Source of Income

Have you claimed or do you intend claiming for payment of disability, dread disease, impairment or any similar benefits with any other assurance company?
Yes No

I "yes", please give details below

Name of assurance company	Contact number	Date of Inception	Estimated Value

Are you currently receiving any other benefits during your disability? Yes No

If "yes", please state details _____

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G. PAYMENT DETAILS (TO BE COMPLETED BY THE CREDIT PROVIDER ONLY FOR CREDIT LIFE CLAIMS)

For your protection, payment will only be made by means of an Electronic Fund Transfer (EFT), which will also ensure a more prompt payment. This payment may only be made to the owner / nominated beneficiary. WE WILL REQUIRE PROOF OF ACCOUNT. e.g. CANCELLED CHEQUE OR BANK STATEMENT THAT REFLECTS THE ACCOUNT NUMBER AND NAME OF THE ACCOUNT HOLDER. PHOTOSTAT COPIES OR FAXED COPIES ARE NOT ACCEPTABLE.

Company name

Policy Loan number | Instalment

Account Holders Name

Bank Name

Branch Name | Branch Code | Account type: Saving | Cheque | Transmission

Account No.

It is very important that you provide us with the correct account number and information of the account to be credited. RP Assurance will not be held responsible for delays and/ or damages incurred due to incorrect provision of information.

H. DECLARATION

I hereby warrant and declare that the foregoing answers and statement are true to the best of my knowledge and belief, and that I have withheld no material fact from RP Assurance. I further declare that the condition giving rise to this claim, was not due in any way to self-inflicted injury or use of alcohol or drugs of any kind, and that I am not insolvent.

I agree that the written statement and affidavits of all the doctors who attended or treated the Life Assured and all other papers submitted in support of this claim shall constitute and are hereby made a part of this claim. I further agree that the supply of this form or any other forms supplemental hereto by RP Assurance shall not constitute an admission by it that there is any assurance in force on the life in question or a waiver of any of its rights or defence in law.

I acknowledge and agree that any benefits payable in respect of this claim shall be forfeited if I, or anyone acting on my behalf or with my knowledge and consent, have knowingly withheld any material fact or submitted any false information in respect of the claim. I further agree that upon payment of the benefits hereby claimed, RP Assurance shall be discharged from all liability in respect of such benefit.

I hereby authorise any medical practitioner, hospital or any other person to furnish to RP Assurance , or its representative any details relating to any illness or injury to the Life Assured or such other information as maybe necessary to consider this claim. I know and understand the confidential nature of medical information. By appending my signatures at the end of this Personal Declaration, I am agreeing that I have given permission to RP Assurance to obtain medical information and evidence from and / or through third parties without it being seen as a breach of my right of privacy and confidentiality. I further agree that any authorised medical personnel or practitioner may release confidential information to RP Assurance or other person acting on their behalf and in such manner or method as RP Assurance may direct.

I indemnify RP Assurance and it's Directors, agents and employees against any claim of whatever nature which may be made against them as a result of arising out of the furnishing of such information. Where the conditions of the contract so allow, I irrevocably authorise RP Assurance to deduct any expenses incurred by it in respect of this claim and for which I am liable from the benefits payable under the contract.

Signed at (Place) | On (date) D D M M Y Y Y Y

Sign Here

Life Assured's Signature | Life Assured's Name (Please print)