Liberty Group Limited – an Authorised Financial Services Provider
Liberty Centre, 1 Ameshoff Street, Braamfontein, Johannesburg, 2001
PO Box 10499, Johannesburg, 2000
Contact Centre number: 0860 456 789 / +27 (0)11 408 4871
Email address: opsclaims@liberty.co.za
Fax no.: (011) 408 2005

CLAIMANT'S STATEMENT FOR LIVING LIFESTYLE

We are required to share, collect and process your Personal Information (PI). Your PI is collected and processed by our staff, representatives or sub-contractors and we make every effort to protect and secure your PI. You are entitled at any time to request access to the information Liberty has collected, processed and shared.

Please send the completed form to Liberty by:

- **Email:** opsclaims@liberty.co.za
- **Fax:** (011) 408 2005
- **Post:** PO Box 10499, Johannesburg, 2000

Standard requirements – please attach copies of the following documents

☐ Copy of life assured's ID document or copy of the back and front of ID smart card.
☐ Proof of Account (POA) - (Please refer to Section 5 – Banking details for full explanation.)
☐ Extract of Medical History (PMA) if the policy is less than 3 years.
☐ All supporting medical documentation.

FAILURE TO RECEIVE ALL THE REQUIREMENTS WILL DELAY THE CLAIM PROCESS.

Contact details for this claim

Surname

First name Initials

Telephone numbers: Work ______ Cell ______ Fax ______

Email address

NOTE: The claims department will send correspondence and copies only where this information has been supplied. In all other circumstances, correspondence will be directed to the policyholder/life assured.

Section 1 – Personal statement by the life assured

Policy number/s

Surname

First name Initials

ID number

Name of medical scheme

Scheme number

Date joined scheme / /

Residential address ______

Postal code ______

Postal address ______

Postal code ______

Contact details

Telephone numbers: Work ______ Cell ______ Fax ______

Home ______

Email address

CLCS0109

1.1 What is your highest academic, professional or trade qualification?

1.2 Have you or the policyholder/life assured ever been insolvent or are any sequestration hearing proceedings, pending or contemplated? ☐ Yes ☐ No

1.3 Are you a smoker? ☐ Yes ☐ No

1.4 Have you ever been advised to stop smoking? ☐ Yes ☐ No

1.5 Do you consume alcohol? ☐ Yes ☐ No

1.6 Have you ever been advised to stop consuming alcohol? ☐ Yes ☐ No

1.7 Have you ever taken recreational drugs? ☐ Yes ☐ No

Section 2 – Medical information relating to claim

2.1 What is the medical reason for the claim being submitted?

2.2 Please provide the date of diagnosis/date the event took place

2.3 The medical condition claimed for is due to: ☐ Disease ☐ Accident

2.4 If the accident was reported to the police, please provide the station at which the accident was reported, the case number and attach a copy of the police report to this claim form.

2.5 If the medical condition resulted from an accident, please provide full details of the accident:

2.6 Please provide the details of all doctors/hospitals/clinics that you have consulted during the past 5 years:

Doctor's name	Contact number	Address	Date of consultation	Reason for consultation

2.7 Please provide details of the doctors/clinics/hospitals who you are consulting regarding your current condition.

Doctor's name	Contact number	Address	Date of consultation	Reason for consultation

2.8 What form of treatment (or medication) are you currently undergoing (or taking)? Please provide details:

3.1 Name and address of last or present employer:

Name

Address

Postal code

3.2 Length of service with employer

3.3 What was your full time occupation immediately before your current disability/impairment began?

3.4 Please provide a breakdown of your duties

Administrative %	Supervisory %	Manual %	Travel %

3.5 Please provide an accurate description of the exact nature and duties of your full time occupation (job description).

3.6 How long have you been in this occupation? ______________________

3.7 What date did you stop working? ______________________

3.8 When do you expect to return to work? ______________________

3.9 Provide details of your current avocations:

____

____

3.10 Have you been offered or have you enquired on any alternate occupation for remuneration by your employer? ☐ Yes ☐ No

If "Yes," please provide duties of alternate occupation offered:

____

____

3.11 Have you accepted the alternate occupation offered? ☐ Yes ☐ No

____

3.12 If "Yes," when do you expect to follow this alternate occupation?

☐ On a full time basis ☐ On a part time basis

3.13 Please list all occupations held in the past 10 years:

Employer	Nature of occupation	Date from	Date to

Section 4 – Information relating to your income (Liberty reserves the right to call for financial evidence in order to assess the claim.)

4.1 What was your taxable income for the past 12 months? R ______________

4.2 What was your commission earned during the past 24 months? R ______________

4.3 Please provide director fees over the past 24 months R ______________

4.4 Have you received any income or any other benefits since disablement? ☐ Yes ☐ No

If "Yes," please state income amount for every month since disablement:

Source of income since disablement	Income amount	Date
	R	
	R	
	R	
	R	
	R	
	R	
	R	

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

If "Yes," please provide details:

Name of insurance company	Policy number	Date of inception	Estimated value
			R
			R
			R
			R
			R
			R

Section 5 – Banking details (excluding credit card)

For your protection payment will only be effected by Electronic Fund Transfer, this will also ensure faster payment. Payment may only be made to the policyholder. Payment can be made to the bank account which is currently paying the premiums subject to the approval of the policyholder. **Should bank details differ to the account details on record, please provide proof of account i.e. a copy of a cancelled cheque OR copy of current bank statement on a bank letterhead OR a copy of a printout from the bank with a bank stamp.**

Account holder's name ______________________

Bank name

Account number | | | | | | | | | | | | | | | | | | | | | | | | |

Branch name ______________________ Branch code | | | | | | | |

Account type: ☐ Cheque ☐ Savings ☐ Transmission

Account holder relationship: ☐ Own ☐ Joint

It is most important to give the correct account number, name and spelling of the account to be credited. Liberty will not bear any responsibility for delays or other damage suffered due to incorrect details being provided.

Section 6 – Declaration

I hereby warrant and declare that the foregoing answers and statements are true to the best of my knowledge and belief, and that I have withheld no material fact from Liberty. 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 statements 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, and further agree that the supply of this form, or any other forms supplemental hereto by Liberty, shall not constitute any admission by it that there is any assurance in force on the life in question or a waiver of any of its rights or defences 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 or consent, have knowingly withheld any material fact or submitted any false information in respect of this claim. I further agree that upon payment of the benefits hereby claimed, Liberty 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 Liberty, or its representative any details relating to any illness or injury to the life assured or such other information as may be necessary to consider this claim. I know and understand the confidential nature of medical information. By appending my signatures at the end of this declaration, I am agreeing that I have given permission to Liberty 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 Liberty or other person acting on their behalf and in such manner or method as Liberty may direct.

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

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

Signed at ______________________ on ______________________

______________________ Signature of policyholder

______________________ Signature of life assured

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MEDICAL CERTIFICATE FOR CLAIMANT'S CONDITION

(To be completed by the doctor/treating specialist)

We are required to share, collect and process Personal Information (PI). PI is collected and processed by our staff, representatives or sub-contractors and we make every effort to protect and secure this PI.

Section 1 – Claimant's details

Policy number/s

Surname

First name — Initials

Doctor's name

Please note that this form must be completed by the doctor (treating specialist) for the condition that the claimant is claiming for.

Section 2 – General medical details

2.1 How long have you known the claimant?

Name of medical professional that referred the claimant to you

2.2 Please provide the diagnosis of the claimant's condition

Date on which the claimant became aware of the condition

Date of first consultation with you regarding this condition

Date of your most recent examination

What was the cause of the condition?

Was there any previous history of the same or similar condition? ☐ Yes ☐ No

If "Yes," please state when and provide details:

2.3 Is there any reason to believe that the claimant's illness, disorder or impairment is in any way due to or arose directly or indirectly, entirely or partially from AIDS, HIV infection or any related disease/disorder including Hepaitis B? ☐ Yes ☐ No

2.4 Is there any reason to believe that the claimant's illness, disorder, injury or impairment is in any way due to or arose entirely or partially from:

a. A wilful self-inflicted injury or attempted suicide? ☐ Yes ☐ No

b. Alcohol consumption or the misuse of narcotics or drugs? ☐ Yes ☐ No

c. Participation in any hazardous sports, pursuits or service on duty in any armed forces? ☐ Yes ☐ No

d. Wilful violation of the law or involvement in civil commotion, riot, strike or unrest? ☐ Yes ☐ No

e. Family history or any hereditary condition? ☐ Yes ☐ No

2.5 Other than the doctors mentioned elsewhere in this report, are you aware if the claimant may have consulted any other doctor or any other person in the medical profession for this condition? ☐ Yes ☐ No

If "Yes," please provide details:

Doctor's name	Qualifications	Contact number

2.6 Has the claimant ever been treated or given advice for substance or alcohol abuse? ☐ Yes ☐ No

If "Yes," please provide details:

Please provide details of any records/reports you have on the claimant's general medical history and attach copies of all tests performed.

Date of consultation	Reasons for consultation	Diagnosis	Treatment

Please note that in the event of any modification or variation of this standard form Liberty will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

Section 3 – Details relating to medical claim

Please complete the section below related to your patient's medical condition and provide us with all relevant investigations and reports including surgical reports and any rehabilitation reports.

3.1 Date of onset of symptoms ______________________

Current symptoms and signs ______________________

Please provide diagnosis ______________________

____

Date of diagnosis ______________________

Please provide details on the criteria used to make the diagnosis (attach copies of all investigations performed):

Date	Investigations that were concluded	Results of investigations

3.2 Details of treatment from initial diagnosis to date:

Treatment	Response to treatment	Compliance to treatment

Are there any further treatment options? ☐ Yes ☐ No

If "Yes," please provide details:

Treatment options	Outcomes expected

3.3 Does the patient have any other medical conditions? ☐ Yes ☐ No

If "Yes," please provide details:

Date of diagnosis	Diagnosis	Previous treatment	Current treatment	Prognosis

Section 4 – Functional abilities

4.1 Please tick the appropriate blocks by indicating the degree and severity level of each Activity of Daily Living (ADL):

Activity	Current limications				Expected future ability		
	No limitation	Mild limitation	Modeate limitation	Impossible	Improve	Remain constant	Deteriotate
Shopping: lifting or carrying groceries	☐	☐	☐	☐	☐	☐	☐
Grasp	☐	☐	☐	☐	☐	☐	☐
Pincer grip	☐	☐	☐	☐	☐	☐	☐
Use of fine motor co-ordination	☐	☐	☐	☐	☐	☐	☐
Holding strengh	☐	☐	☐	☐	☐	☐	☐
Grip strength	☐	☐	☐	☐	☐	☐	☐
Assisted walking	☐	☐	☐	☐	☐	☐	☐
Walking (non-strenuous) over level ground	☐	☐	☐	☐	☐	☐	☐
Walking (strenuous) over uneven ground	☐	☐	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐	☐	☐
Squatting	☐	☐	☐	☐	☐	☐	☐
Stooping	☐	☐	☐	☐	☐	☐	☐
Rise to standing position unaided	☐	☐	☐	☐	☐	☐	☐
Bladder status	☐	☐	☐	☐	☐	☐	☐
Bowel status	☐	☐	☐	☐	☐	☐	☐
Visual fields	☐	☐	☐	☐	☐	☐	☐
Visual acuity – with glasses	☐	☐	☐	☐	☐	☐	☐
Light manual labour	☐	☐	☐	☐	☐	☐	☐
Operating light machinery	☐	☐	☐	☐	☐	☐	☐
Operating heavy machinery	☐	☐	☐	☐	☐	☐	☐
Driving a light motor vehicle	☐	☐	☐	☐	☐	☐	☐
Driving a heavy motor vehicle	☐	☐	☐	☐	☐	☐	☐
Work in cramped conditions	☐	☐	☐	☐	☐	☐	☐
Work in dusty environment	☐	☐	☐	☐	☐	☐	☐
Work in a fume environment	☐	☐	☐	☐	☐	☐	☐
Higher cognitive functioning	☐	☐	☐	☐	☐	☐	☐
Short term memory	☐	☐	☐	☐	☐	☐	☐
Long term memory	☐	☐	☐	☐	☐	☐	☐
Attention	☐	☐	☐	☐	☐	☐	☐
Language function	☐	☐	☐	☐	☐	☐	☐
Mental behaviour ie. concentration, moods etc.	☐	☐	☐	☐	☐	☐	☐
Interaction with others	☐	☐	☐	☐	☐	☐	☐
Seated/sedentary tasks	☐	☐	☐	☐	☐	☐	☐
Participation in sports	☐	☐	☐	☐	☐	☐	☐
Participation in hobbies	☐	☐	☐	☐	☐	☐	☐

4.2 Permanent inability to perform basic ADL and instrumental ADL's:

Activity	Description	Current limitations				Expected future ability		
Basic ADL's		**Non**	**Mild**	**Moderate**	**Impossible**	**Improve**	**Remain constant**	**Deteriorate**
Washing	The ability to wash oneself without physical assistance or supervision, this included transferring in and out of the bath or shower	☐	☐	☐	☐	☐	☐	☐
Dressing	The ability to independetly put on or take off all garments, including the security and unfastening therof. Where appropriate, this includes any braces, prosthesis or other surgical procedures.	☐	☐	☐	☐	☐	☐	☐
Feeding/eating	The ability to eat independently once food has been prepared and made available.	☐	☐	☐	☐	☐	☐	☐
Continence	The ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained.	☐	☐	☐	☐	☐	☐	☐
Transferring	The ability to independently transfer from the bed to a chair with the assistance of a walking aid	☐	☐	☐	☐	☐	☐	☐
Instrumental ADL's								
Telephone use (communication)	The ability to use a telephone indepently, ths includes answering the phone on an incoming call, being able to hold a basic conversation, as well as the ability to dial a well known or written down number.	☐	☐	☐	☐	☐	☐	☐
Food preparation	The ability to prepare and serve simple, everyday meals. This includes the ability to perform simple measurements, preparation activities and having awareness of general kitchen safety.	☐	☐	☐	☐	☐	☐	☐
Housekeeping	The ability to perfom light household chores susch as making a bed, washing dishes and maintaining a reasonable level of cleanliness.	☐	☐	☐	☐	☐	☐	☐
Transport	The ability to safely drive a car (including getting into and out of the car) or the ability to use public transport including being able to provide a drop-off address, and reaching a public transport pick up point.	☐	☐	☐	☐	☐	☐	☐
Handling finances	The ability to perform basic calculations such as purchasing daily consumables, including the ability to perform a basic calculation of what money is required to pay for purchases and what change is due.	☐	☐	☐	☐	☐	☐	☐
Writing	The ability to take down a simple message or complete a simple form requiring personal details such as name, date or birth and address.	☐	☐	☐	☐	☐	☐	☐

4.3 Does the patient require assistance with activities of daily living despite being on treatment? If "Yes", please provide details: ☐ Yes ☐ No

Activity	Assistance required

4.4 Does the patient require supervision of daily living despite being on treatment? If "Yes", please provide details: ☐ Yes ☐ No

Activity	Assistance required

4.5 Any assistive devices or mechanical support for daily functions required? If "Yes", please provide details: ☐ Yes ☐ No

4.6 Has the claimant ever received, or is the claimant currently receiving treatment from anybody i.e. occupational therapy/physiotherapy/ biokineticist/psychologist and if so are these modalities of treatment likely to improve outcomes or is the patient at the maximum recovery. ☐ Yes ☐ No

If you are in possession of these reports, please provide copies or alternatively provide details below:

Name of provider	Contact number

4.7 What are the chances of recovery? ☐ Good ☐ Fair ☐ Poor ☐ Nil

If improvement is expected, please indicate the time period in which that improvement is expected.

Are any residual problems likely? If "Yes", please provide details:

Section 5 – Declaration

I, ______ a duly registered doctor/treating specialist, hereby certify that the information is an accurate reflection of this patient's medical history and is true, correct and complete.

Signed at ______ on ______

Stamp

Signature of doctor/treating specialist

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