CLAIM FORM
(Disability)

Completed and signed documents
should be returned to:
claims@ukheshe.co.za
or contact (010) 444 0040 for assistance

We pay a lump sum if the insured person has suffered total, permanent and irreversible disability. This can mean loss of a body part, or the loss of use of a body part. The lump sum amount is calculated as follows:

- **Loss of or loss of use of:**
  - o **Both hands or both feet** (at or above the ankle joint/at or above the wrist): 100% of cover
  - o **One hand or one foot** (at or above the ankle joint/at or above the wrist): 50% of cover
  - o **One hand and one foot** (at or above the ankle joint/at or above the wrist): 100% of cover
  - o **Both eyes** (permanent and irreversible loss of all vision with no light perception in both eyes): 100% of cover
  - o **Speech** (permanent and irreversible loss of ability to speak as a result of injury or disease to vocal cords or brain): 100% of cover

- **3rd degree burns** >40% of body surface: 100% of cover

- **3rd degree burns** 20-40% of body surface: 50% of cover

This declaration will form the basis on which your claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Any misstatement could lead to the claim not being admitted.

Section A: Insured details

Policy number: _____

Full names: _____

Surname: _____

Gender: Male _____ Female _____

Date of birth: _____

ID number: _____

Address: _____

_____

_____

Telephone number (home): _____

Cell number: _____

Email address: _____

Section B: Claim Cause

Please confirm the claim cause:

Loss of, or loss of use of:	**X**
Both hands (at or above the wrist)	
Both feet (at or above the ankle joint)	
One hand (at or above the wrist)	
One foot (at or above the ankle joint)	
One hand AND one foot (at or above the wrist or ankle joint)	
Both eyes (permanent and irreversible loss of all vision with no light perception in both eyes)	
Speech (permanent and irreversible loss of the ability to speak as a result of injury or disease to the vocal cords or brain)	
3rd degree burns (>40% of body surface)	
3rd degree burns (20-40% of body surface)	

Section C: Accident Details

(Please fill this section in where the claim is as a result of an accident)

Date and time of accident causing the injury: _____

Was the accident reported to the police: _____

If so, please provide:

a) Case reference number: _____

b) Name and Rank of Investigating Officer: _____

c) Name of Police Station and Contact Number: _____

Please provide a brief description of the accident: _____

_____

_____

_____

_____

If you were involved in a motor vehicle accident, please provide the accident report form.

Section D: Medical Details

Please fill in this table. This gives us more information about where you were hospitalised and what treatment you received for the injury or illness that lead to the physical impairment that you are claiming for. This should be filled in regardless of the cause of your disability.

Hospital	Condition Treated For	Date of admission	Date of discharge	Surgery performed (if any)	Details of treatments, medications, etc.

Details of any surgery undergone, related to this incident: _____

_____

_____

_____

_____

_____

_____

Section E: Details of medical practitioners and rehabilitation experts, relating to this incident.

Please complete the tables below regardless of the cause of your disability. This will give us more information about the doctors who treated you for the illness or injury that lead to this claim (in case we need to contact them).

General Practitioner or rehabilitation expert

Name of Doctor	Contact details of doctor	Name of facility (e.g. hospital name)	Consultation Date	Treatment details	Date of last visit to doctor

Specialist

Name of Doctor	Contact details of doctor	Name of facility (e.g. hospital name)	Consultation Date	Treatment details	Date of last visit to doctor

Section F: Supporting documentation required

The following documents must be submitted with the claim form:

1. Copy of the life insured's ID document

2. Medical report completed by the doctor/s who treated the life insured supporting the permanent disability.

3. Nominated credit provider statements reflecting account details and latest outstanding balance where the policy is ceded to a credit provider.

Section G: Declaration

I declare to the best of my knowledge that all the particulars given on this claim form are true and correct, and that no material information has been withheld or omitted. I hereby authorise any medical practitioner, hospital or any other person who has information about my health to provide such information to uKheshe Payment Solutions, or persons acting on behalf of uKheshe. I hereby authorise uKheshe Payment Solutions to furnish any medical information contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, to any medical practitioner or allied medical practitioner (e.g. occupational therapist, physiotherapist or psychologist) who may require such information for the purpose of assisting uKheshe Payment Solutions in the assessment of my claim.

Signature_____

Date:_____