CREDIT LIFE

DISABILITY CLAIM FORM (CLA 6)

Kindly answer all questions in full and complete in black ink. If you have any problems completing the form, please call us on (061) 295 2876. Send the completed form to us by email at claimsnednamibialife@nedbank.com.na

Note: Original claim documents should be submitted to NedNamibia Life Assurance Company Limited office directly or at your nearest Nedbank branch. Although NedNamibia Life Assurance Company will commence the assessment of the claim on receipt of any electronic submission, the finalisation of the claim and ultimate disbursement under the Policy will only happen once the original documentation has been received by either NedNamibia Life Assurance Company Limited or any Nedbank Branch.

CHECKLIST (FOR CLIENT)

- ☐ A completed Credit Life Disability Claim Form (CLA6)
- ☐ Original certified copy of the Insured's identity document
- ☐ Original certified copy of Health Passport *(All medical records)*
- ☐ Original certified copy of Medical Aid card *(if applicable)*
- ☐ Doctor's medical report (CLA4)
- ☐ Original certified copy of Medical Boarding confirmation
- ☐ Employer Report (CLA5)
- ☐ Original certified copy of discharge certificate *(if applicable)*

CHECKLIST (FOR OFFICIAL USE ONLY)

- ☐ Copy of the initial Loan Application Form
- ☐ Copy of Credit Life Application Form
- ☐ Statement of Account (instalment history)

NedNamibia Life Assurance Company **will only accept** original certified copies of the Supporting Document, duly certified by a Commissioner of Oaths.

NedNamibia Life Assurance Company reserves the right to request any additional information and documentation it deems necessary to verify the claim. Incomplete details and unclear documentation may cause delays and may need to be requested again.

TO BE COMPLETED BEFORE A COMMISSIONER OF OATHS

1. DETAILS OF CLAIMANT (LIFE INSURED)

Full name

ID/Passport

Address
- Line 1
- Line 2
- Suburb
- Town
- Code

Email address

Tel (h) | Tel (w) | Cell

What was your main occupation at the time of commencement of the disability?

Please describe your duties fully:

Name of employer at the time of the disablement

Address of employer at the time of the disablement
- Line 1
- Line 2
- Suburb
- Town
- Code

Nature of business

Medical aid - Name of fund | Membership number

2. MEDICAL HISTORY

Which injury or illness has given rise to this claim?

When did you first consult a medical practitioner in connection with this condition? d d m m y y y y

2. MEDICAL HISTORY *(Continued)*

Is the disability permanent? ☐ Yes ☐ No

Are you still under treatment? ☐ Yes ☐ No

If '**YES**', please give the name and address of the doctor/specialist presently treating you:

Did any of the following contribute in any way to your disability?

Previous illness, injury, mental or physical defect	☐ Yes	☐ No
Hazardous occupation, pastimes or pursuits	☐ Yes	☐ No
Failure to seek timely and adequate medical attention or to heed medical advice given	☐ Yes	☐ No
Consumption of alcohol or the taking of drugs or narcotics (except under medical direction)	☐ Yes	☐ No
Violation of the criminal law, wilful or negligent exposure to peril or provoked assault	☐ Yes	☐ No
Attempted suicide or self-inflicted injury	☐ Yes	☐ No

If you answered '**YES**' to any of these items, please give full details or circumstances:

Medical Records: Hospitalisation, medical treatment, operations, etc. *(complete fully)*

Date: From/To	Hospital	Purpose/Treatment	Doctor/Specialist	Doctors contact details

3. OCCUPATIONAL PERFORMANCE

Current work status ☐ At work ☐ Working part-time

If on sick leave ☐ Paid ☐ Unpaid

If not at work, please indicate ☐ Medically boarded ☐ Early ill-health retirement ☐ Other *(Specify)*

Is the claimant expected to return to work? ☐ Yes ☐ No

If yes, in what capacity? ☐ Same ☐ Adapted ☐ Alternative

Expected date of return d d m m y y y y

4. DECLARATION BY CLAIMANT

I,

hereby declare that I am the person assured under the aforementioned policy and that all particulars given are, to the best of my ability/knowledge, both true and correct and complete in all its aspects. I hereby authorise:

1. Any medical practitioner, nursing home, institution or other medical authority to furnish NedNamibia Life Assurance Company Limited with all such information as they may require in connection with my Disability; and the current claim
2. My employer(s) to furnish NedNamibia Life Assurance Company Limited with all such information as they may require in connection with my occupation.

Signature of claimant at on d d m m y y

Residential address

Line 1

Line 2

Suburb

Town Code

Telephone no.

5. DECLARATION BY COMMISSIONER

I hereby declare that the deponent has sworn to and signed this statement in my presence at

on the day of and he/she* declared as follows:

1. that the facts herein contained fall within his/her personal knowledge and that he/she* understands the contents hereof;
2. that he/she* has no objection to taking the oath;
3. that he/she* regards the oath as binding on his/her conscience and has declared as follows: ***"I swear that the contents hereof are true and correct, so help me God."***

**delete which is not applicable*

Signature of Commissioner of Oaths

Full names

Address
- Line 1
- Line 2
- Suburb
- Town — Code

Capacity — Area

Official stamp

6. FOR OFFICIAL USE | BANK STAFF DECLARATION

Employee Number

I, [First name(s)]

(Surname)

declare that the above information is a true reflection of the information furnished by the claimant, and that the claim form has been completed in full and that all the requirements specified in the checklist accompany this claim form. All requirements are clear, legible documents and there are no evident alterations. I further declare that the claimant:

[First name(s)]

(Surname)

has identified him/herself by means of a valid ID document. | ID no *(copy attached)*

Signed at Branch

on d d m m y y at h h m m

CREDIT LIFE
EMPLOYER'S REPORT (CLA 5)

TO BE COMPLETED BY THE EMPLOYER OF THE CLAIMANT

This report is required to substantiate a disability claim under a policy issued by NedNamibia Life Assurance Company Limited and will be considered strictly confidential.

Life Assured

ID/Passport

1. EMPLOYMENT DETAILS OF CLAIMANT

Name of Company

Company Registration Number

Postal address of workplace
Line 1
Line 2
Suburb
Town Code

Physical address of workplace
Line 1
Line 2
Suburb
Town Code

Name of contact person at workplace

Telephone no. at workplace

Job title of claimant

Date on which claimant commenced service at company d d m m y y y y

Specify the date from which the claimant ceased to be actively at work as a result of the condition on which this claim is based d d m m y y y y

2. OCCUPATIONAL PERFORMANCE

Current work status ☐ At work ☐ Working part-time

If on sick leave ☐ Paid ☐ Unpaid

If not at work, please indicate ☐ Medically boarded ☐ Early ill-health retirement

Is the claimant expected to return to work? ☐ Yes ☐ No

If '**YES**', in what capacity? ☐ Same ☐ Adapted ☐ Alternative

Expected date of return d d m m y y y y

Describe why the claimant is considered unable to return to work at present

Has the condition caused absence of work during the past two years? ☐ Yes ☐ No

If '**YES**', attach sick leave/attendance records, which indicate period and reason for absence during the past two years.

3. DECLARATION BY EMPLOYER

I hereby declare that the above information is true and correct, and that no information has been withheld or omitted.

Signed at on d d m m y y

Name in block letters Designation

Employer stamp

CREDIT LIFE

MEDICAL REPORT IN RESPECT OF DISABILITY CLAIM (CLA 4)

This report is required to substantiate a disability claim under a policy issued by NedNamibia Life Assurance Company Limited and will be considered strictly confidential.

Full name of claimant

What was your main occupation at the time of commencement of the disability?

1. CAUSE OF DISABILITY

The following questions apply only to the cause of disability

Cause of disability

Date of first symptoms *(if not accidental)* d d m m y y y y

When were you first consulted in connection with this disability? d d m m y y y y

If cause of disability is accidental, please state:

Date d d m m y y y y

Nature of accident d d m m y y y y

2. MEDICAL ATTENDANT

Are you the claimant's usual medical attendant? ☐ Yes ☐ No

If '**YES**', how long have you attended him/her? d d m m y y y y to d d m m y y y y

If '**NO**', who is his/her usual attendant?

Name and contact details of any other doctors/specialists/hospital referred to or consulted by

3. NATURE OF DISABILITY

Please attach copies of any X-Rays, Scans, ECG's, Lab reports, specialist reports and/or your clinical records/reports (Submission is compulsory)

Describe fully the nature and extent of the claimant's disability

Is this disability permanent? ☐ Yes ☐ No

Describe the treatment received by the claimant for this disability

How successful has this treatment of this disability been?

Describe fully the claimant's present condition

Please state details of any further treatment/operations contemplated

3. NATURE OF DISABILITY *(Continued)*

What is the prognosis of this case, taking into account the possible outcome of further treatment/operations?

Has the claimant had any blood/HIV antibody tests? ☐ Yes ☐ No

If 'yes', give date d d m m y y y y and results

Has Infection by the Human Immunodeficiency Virus or the mutants, derivatives or variants thereof, including acquired immunodeficiency syndrome (AIDS or AIDS-related complex (ARC) been a contributing factor towards the claimant's present condition?

General comments

PLEASE INCLUDE COPIES OF ALL ECGs, TEST AND REPORTS THAT HAVE BEEN CONDUCTED

4. DECLARATION BY MEDICAL ATTENDANT

Signed at on d d m m y y

Full names

Address
Line 1
Line 2
Suburb
Town Code

Practice no. Tel no.

Note: Kindly complete and send directly to: The Claims Department NedNamibia Life Assurance Company Ltd, via email on _____ alternatively via postal service, P.O Box 1 Windhoek, Namibia.
The fee of this medical report will be paid by NedNamibia Life Assurance Company Ltd according to the tariff laid down by the Namibian Medical and Dental Council.