# CREDIT LIFE

## PERSONAL CATASTROPHE CLAIM FORM (CLA 8)

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 Personal Catastrophe Claim Form (CLA8)
- ☐ 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 (CLA7)

### 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

Medical aid - Name of fund | Membership number

Occupation at time of personal catastrophe

## 2. PERSONAL CATASTROPHE

**ALL QUESTIONS APPLY TO THE PERSONAL CATASTROPHE**

Name of condition

Date of first symptoms/awareness of this condition: d d m m y y y y

Date when you first consulted a doctor about this condition: d d m m y y y y

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

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

| Date: From/To | Hospital | Purpose/Treatment | Doctor/Specialist | Doctors contact details |
|---|---|---|---|---|
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## 3. DECLARATION BY CLAIMANT

I, 

hereby declare that I am the person insured under the aforementioned policy and that all particulars given are, to the best of my ability/knowledge, both true and correct in all its aspects. I hereby irrevocably authorise NedNamibia Life Assurance Company Limited:

1. To obtain from any medical practitioner, nursing home, hospital, institution, medical authority or other person in possession of any information regarding my health, to give any information which NedNamibia Life Assurance Company Ltd deems necessary; and
2. To share with other Insurers the information contained in this proposal or in any related policy or other document, either directly or through a data base operated by or for insurers as a group at any time and in such detailed, abbreviated or coded form as may from time to time be decided by NedNamibia Life Assurance Limited or by the operators of such data base.

Signature of claimant | at | on d d m m y y

Residential address
Line 1
Line 2
Suburb
Town | Code

Telephone no.

The above declaration was sworn to before me on d d m m y y y y

## 4. 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 content 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

## 5. 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

## DOCTOR'S MEDICAL REPORT (CLA 7)

To be completed by the Claimant's **Medical Attendant** and returned to NedNamibia Life Assurance Company Limited.

Full name of claimant

Date of event d d m m y y y y

## 1. NATURE OF PERSONAL CATASTROPHE

Nature of the claimant's personal catastrophe

Date on which claimant first became aware of the condition giving rise to the claim d d m m y y y y

Date of commencement of first diagnosis d d m m y y y y

When were you first consulted for this condition? 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 the claimant prior to the inception of the Credit Life Policy as well as during the life-span of the Policy up until time of the personal catastrophe.

## 3. DETAIL OF PERSONAL CATASTROPHE

What treatment is being given and what types of medication are being prescribed?

Are you aware of anything in the claimant's previous history that is likely to have contributed to his/her present condition?

What are the claimant's present limitations – physically and mentally?

What is the prognosis?

In the case of **heart disease**, please elaborate on:

History of chest pain

New ECG changes

Elevation of cardiac enzymes

## 3. DETAIL OF PERSONAL CATASTROPHE *(Continued)*

In the case of **any of the following** , please describe in detail in the space provided below. For **cancer**, please include classification and staging.

Cancer

Kidney failure

Surgery for coronary heart disease
*(excluding angioplasty and/or any intra-arterial procedures)*

Surgery for a disease of the aorta

Replacement of a heart valve

Organ Transplant

Coma

Major Burns
*(third degree burns covering at least 20% of the body surface)*

Loss of limb/speech

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?

**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.