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Parktown
2193



Postnet Suite 409, Private Bag X30500, Houghton, 2041

T 0860 64 54 33
E claims@go.miwaylife.co.za

Terminal Illness Claim Form

To claim, please complete this form and email it back to us at claims@go.miwaylife.co.za. Or you can call our Servicing Department on 0860 64 54 33.

Attach the following documents to the completed claim form:

1. Fully completed Terminal Illness Claim Form
2. Certified copy of Life Assured's ID
3. Bank statement stamped by the bank
4. Copies of medical aid claim statement (if applicable)
5. All available reports/tests, such as Histology Report, Blood Test Report, X-ray Report, CT/MRI Scan Report, ECG, and Angiogram results in the event of cardiac claims and any other result pertinent to the claim event

MiWayLife reserves the right to request further information that they deem necessary to complete the assessment of the claim.

Section A: Particulars of the Insured

- a. Full first name(s) and Surname: _____
- b. ID Number: _____
- c. Date of Birth: _____
- d. Marital status (Single / Married / Divorced / Widowed / Permanent Life Partner): _____
- e. Residential Address: _____

- f. Telephone Number (Home, Work and / or Cell): _____
- g. Name of Employer: _____
- h. Medical Aid Name: _____ Medical Aid no. _____

Section B: Details of the Terminal Illness

- a. What is the cause of your claim? _____
- b. Date of first symptoms: _____
- c. When was the first time you saw a doctor about this condition? _____
- d. Date on which your terminal illness was first diagnosed? _____
- e. How much are you claiming? Please write 50% or 100% _____
- f. Please provide the names of all doctors, hospitals, and clinics that you consulted in connection with the conditions:

Dr: _____ Address _____

Postal Code: _____

Work Tel: _____ Date/s visited: _____

Dr: _____ Address _____
_____ Postal Code: _____

Work Tel: _____ Date/s visited: _____

Dr: _____ Address _____
_____ Postal Code: _____

Work Tel: _____ Date/s visited: _____

Have you been hospitalised? Yes or No _____

Please provide the name of the hospital and date of hospitalisation and discharge _____

g. Details of the doctor/specialist who is currently treating your condition:

Doctor's Surname: _____ Initials: _____

Physical address: _____

Code: _____

Telephone number: _____

h. Details of your family doctor:

Doctor's Surname: _____ Initials: _____

Physical address: _____

Code: _____

Telephone number: _____

When was the last time you saw this doctor? Please provide details _____

Section C: Declaration and Authorisation by the Insured

Declaration

I _____ (Full First name(s) and Surname printed),
declare that the above details are true and correct. I understand that in the event that this claim or any supporting
documentation (or claim documentation) is found to be fraudulent MiWayLife reserves the right to proceed with the
appropriate action against the claimant.

Authorisation

I further irrevocably authorise any Doctor or any other person who has treated me, or any hospital or other institution
which has medical information about me, to disclose such information to MiWayLife.

Signature of Life Assured _____ Date: _____

MiWayLife Disclosures

POPIA

MiWayLife cares about your privacy. To provide you with our service, we and our service providers must process the personal information you provide us with by completing this form. We will treat this information with caution, and we have put reasonable security measures in place to protect it.

FICA

In line with the applicable anti-money laundering laws of South Africa, we are required to obtain specific information and evidence to verify your identity when applying for cover and on an ongoing basis. If we do not receive the requested information within a reasonable time, we may be unable to render our services.