momentum
corporate

Critical Top-up - employer / employee declaration

Employer and employee to complete this form

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

The information requested on this declaration is required and will form the basis on which the claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Omission or distortion of information could be used as a basis for the claim being declined.

Please attach a copy of the member's payslip as at date of diagnosis.

We will also require the Critical Top-up Confidential Medical Report and copies of all relevant clinical investigation findings in order to assess this claim.

Completed form together with supporting documents to be faxed to 021 917 3711 or emailed to wcc@momentum.co.za or posted to PO Box 2212, Bellville, 7535, attention Momentum Group Insurance disability claims.

1. Scheme details

Scheme name

Employer name

2. Member details

Title | Initials

First name/s

Surname

Date of birth D D - M M - Y Y Y Y

RSA ID Yes ☐ No ☐ | ID / Passport no

Passport country of origin

Gender Male ☐ Female ☐

Marital Status Married ☐ Single ☐ Divorced ☐ Widowed ☐ Permanent Life Partner ☐

Home language

Email

Telephone - work | Fax

Telephone - home | Cell

Residential address

Postal code

Postal address

Postal code

Income tax office | Income tax number

Medical aid name | Medical aid number

Postal address

Date employment commenced D D - M M - Y Y Y Y | Date of joining disability scheme D D - M M - Y Y Y Y

Company/employee No

Gross annual income R

3. Employer details

Contact person at company

Designation

Telephone | Fax

Email

Company address (head office)

Postal code

Company address (office/branch)

where main member works | Postal code

4. Medical details

Diagnosis being claimed for

Date of diagnosis D D - M M - Y Y Y Y

Date of birth D D - M M - Y Y Y Y

When did you see a doctor about your current illness/impairment for the first time? D D - M M - Y Y Y Y

Please supply name and contact details of the doctor consulted.

Name

Address

Postal code

Tel No. | Fax

Email

Have you suffered from this illness/impairment previously? Yes ☐ No ☐

If Yes, give details (e.g. date diagnosed, treatment received, name of treating doctor etc.).

Have you previously received any benefits from any life insurance company? Yes ☐ No ☐

If Yes, give details (e.g. type of benefit, when received, name of insurer etc.).

Please give the name, postal address, email address and tel number of your regular family doctor/general practitioner.

Name

Address

Postal code

Tel No. | Fax

Email

Since when has he/she been your family doctor? D D - M M - Y Y Y Y

When was your last consultation? D D - M M - Y Y Y Y

If you have changed general practitioners in the last two years, please give details of all previous attending practitoners.

Name	1st consult date	Last consult date	Tel no.	Hospital/Address	Patient No.

Please give the names of all doctors, specialists and hospitals you have consulted in connection with your impairment/disability.
Please provide us with the telephone number and email address as we may need this to communicate with your doctor.

Date from				
Date to				
Hospital / Doctor				
Speciality				
Tel no.				
Email address				
Patient Number				

Details of any hospitalisations within the last two years.

Name of hospital	Admission date	Discharge date	Reason for admission	Surgery performed

5. Banking details

To whom must benefit be paid? Employer ☐ Member ☐

Name of account holder

Name of bank

Account number Branch no.

Account type Current/cheque ☐ Savings ☐ Transmission ☐

6. Supporting documents required

A copy of payslip is attached Yes ☐ No ☐

7. Declaration by employer

I declare that all the information given on this form and accompanying documents is true and correct and that no material information has been witheld. I give Momentum Corporate permission to share this information with any other party who requires this information for the purpose of assisting Momentum Corporate in the assessment and management of this claim.

I declare that I have the necessary authority to complete and sign this form on behalf of the employer.

Name of person completing this form

Designation

Contact number

Email

Signature of Employer

Date D D - M M - Y Y Y Y

8. Member's declaration and consent to collect and share personal and health information

First name/s

Surname

Date of birth D D - M M - Y Y Y Y

RSA ID Yes ☐ No ☐ ID / Passport no

Passport country of origin

Declaration

I (full name of member), declare that all the information given on this claim form is true and correct, and that no material information has been withheld. I understand that any incorrect and/or misrepresentation of information could be used as a reason for the claim not being approved.

Consent to collect and share personal, medical and health information

Momentum Corporate may process all information provided on this form. Information will be processed in accordance with the Protection of Personal Information Act, 2013 and Momentum Corporate's strict policies on protecting the confidentiality of my personal information. Momentum Corporate's full privacy policy can be found on www.momentum.co.za.

I consent and give permission for:

- any health practitioner (e.g. doctor, psychiatrist, etc.), allied health practitioner (e.g. occupational therapist, psychologist etc.), medical institution, medical aid, employer, insurance company, health risk management service provider appointed by my employer/policyholder or any other person or institution that has information about my health, employment related activities and personal information, to provide this information to Momentum Corporate or any third party nominated by Momentum Corporate who requires this information for the purposes of assessing and managing my claim.
- Momentum Corporate to share any medical, occupational and personal information contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, with a health practitioner, allied health practitioner, health risk management service provider appointed by my employer/policyholder, or any third party nominated by Momentum Corporate who may require such information for the purpose of assisting Momentum Corporate in the assessment and management of my claim or for assessing the payment of a benefit under a risk policy where I am the policyholder.
- Momentum Corporate to share any medical, occupational and personal information contained in medical reports or otherwise, which they have obtained in the course of the assessment of my claim, with other insurers for the purpose of assessment of any related claim that I might have against that insurer, and with Astute for statistical purposes and for the management of over insurance and fraud in the insurance industry.
- Momentum Corporate to send correspondence, which may include personal and special personal information, regarding my claim to my employer/policyholder or its appointed intermediary. The purpose of this correspondence is to inform them of the status and outcome of my claim.
- Momentum Corporate to provide my employer/policyholder or its appointed intermediary with regular claims status reports which will contain personal information. Momentum Corporate will not share any health related information in the status reports unless I have given express written consent.
- Momentum Corporate to share all medical and health related information (special personal information) with the following third parties: (please select from the list below)

☐ Employer/policyholder (including their representatives) involved with my claim

☐ Financial Advisers and Intermediaries appointed by my employer or myself

☐ Any other person/s appointed by me in writing

☐ All of the above

☐ None of the above

Momentum Corporate will share medical and health related information with third parties at its discretion. I confirm that I will not hold Momentum Corporate, its employees, directors or agents liable in any way and I indemnify and hold Momentum Corporate harmless for the sharing of health related information in line with this consent.

I confirm that I know and understand this consent I am providing to Momentum Corporate and that I am doing so voluntarily.

Click here to read the full consent document (https://www.momentumpartnershipconnect.co.za/momentum-corporate-popia-member-document/).

Signature of Member **Date** D D - M M - Y Y Y Y

***If member is unable to sign the consent due to medical incapacity, please contact us so that we can further assist.**

Options to sign the form:

1. Print out the form, sign and scan it and send it back via email to wcc@momentum.co.za , fax it to Fax +27 (0)21 917 3711 or posted to PO Box 2212, Bellville 7535, attention Momentum Group Insurance disability claims.
2. Place your scanned signature in the signature block by following the steps outlined below.
   - Store your scanned signature as a PDF document in a safe place on your computer.
   - Select the 'comments' tab from your menu in Adobe.
   - Select the 'add stamp' icon.
   - Select custom stamps.
   - Create custom stamps.
   - You can now browse and upload your signature to save it as a custom stamp under 'sign here' in Adobe.
   - You can now go back to your 'stamps' icon and select 'sign here' and select your saved signature.
   - Place it in the document and save the document.

submit form save form print

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