FAMILY RESPONSIBILITY RIDER BENEFIT – TERMINAL ILLNESS BENEFIT FORM (CHILD) (TO BE COMPLETED BY PPS MEMBER)

The Professional Provident Society Holdings Trust No IT 312/2011 (PPS Holdings Trust) is a Registered South African Trust. Professional Provident Society Insurance Company Limited Reg No. 2001/017730/06 ("PPS Insurance"). PPS is a Licensed Insurer and Financial Services Provider

Please return completed forms to claims@pps.co.za or fax 011 644 4520

PART A: MEMBER DETAILS

Member number:

Initials: Surname:

Date of birth: D D / M M / Y Y Y Y

Email:

Cellular: 0

PART B: DETAILS OF THE CLAIM

Particulars of child

Name:

Surname:

National ID number/Passport if no ID:

Biological Child Step Child Adopted Child

NOTE Refer to the bottom of the form for a list of required supporting documents.

1. Please state the medical condition for which you are claiming:

2. Provide brief details of the chronological history (date of onset and progression up to now) of the medical condition:

3. Please state the name(s) of the doctor(s)/ dentist(s) and allied medical practitioners that attended to your child, in respect of this current illness.

It may be necessary for our claims area to contact the below doctors for further information.*

Practitioner's Surname and Initials	Consultation Date	Tel	Fax	Email

* Please refer to Declaration

4. Provide details of the hospital admission:

Name of hospital:

Date admitted: D D / M M / Y Y Y Y Date discharged: D D / M M / Y Y Y Y

PART C: BANKING DETAILS FOR CLAIM BENEFIT VIA EFT

NOTE *Only complete when payment is to be made into a bank account other than from which premiums are collected:*

(Please attach a cancelled cheque or bank statement stamped by the bank).

Name of account holder:

Name of bank:

Account number:

Branch code:

Branch:

Type of Account: Current ☐ Savings ☐ Cheque ☐ Transmission ☐

INDEMNITY *Please take note that PPS will not be held liable for incorrect payments, if the information received is incorrect.*

PART D: DECLARATION

I specifically authorise PPS Insurance to communicate any requirement to my/member's financial advisor which may entail providing information regarding the current medical condition. YES ☐ NO ☐

Financial Advisor's Name:

Financial Advisor's Email:

I certify that all the above information is true and correct and I/we authorise PPS Insurance to:

a) Access any information which it deems necessary to assess any insurance risk or to consider a claim and I understand that if I choose not to provide this information PPS will not be able to assess my claim for insurance.

b) Share with other insurers and their representation body any information in the possession of PPS Insurance, either directly or through a database operated by, or for insurers as a group and authorise PPS to also collect my personal information from other insurers as exchange of information helps to save costs and combat fraud. PPS can further process any such information in accordance or compatible with the purpose for which it was collected.

c) Disclose any information to the PPS Holdings Trust, subsidiaries, affiliates, Profmed or other persons provided that it is necessary to properly underwrite, manage, assess the claim or service the policy, policy assets or myself. PPS Insurance may be required to disclose your information to regulatory or government agencies.

d) Obtain credit information from any person or institution.

AND

I/we understand that I can request details of the information held by my insurer and request its correction where appropriate.

AND

I/we authorise a doctor, hospital, medical aid or any other person to provide this information to PPS.

PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS will adhere to any laws governing the protection of (and access to) personal information; and will not use your information for any purpose not provided for in your Policy Contract and in this Part D.

Signature of policyholder:

Signature of spouse or child over 18 years of age:

Signed at (Place): on this day of 20

PROCEDURE FOR CLAIMING FAMILY RESPONSIBILITY RIDER BENEFITS

To enable the timely assessment of the claim all required details should be fully completed. Should information be omitted there may be a delay in the finalisation of the claim.

Additional information (at PPS' cost) may be requested from either the policyholder or any Medical Practitioner to finalise the claim. The policyholder and/or the Medical Practitioner will be notified if additional information is required.

In addition to the medical information listed above, claims in respect of the Family Responsibility Rider Benefit should be submitted with the following supporting documents:

Claim for biological child

Copy of unabridged birth certificate

Proof of hospitalisation

Claim for stepchild

Copy of unabridged birth certificate

Copy of marriage certificate

Proof of hospitalisation (Admission and discharge dates / ICD 10 codes / patient names)

Claim for adopted child

Copy of unabridged birth certificate

Proof of hospitalisation (Admission and discharge dates / ICD 10 codes / patient names)

Adoption order

NOTE If your benefit commenced on or after 01 April 2017 and you had similar cover at another company, kindly provide us with a copy of your membership certificate reflecting the date of inception, the date of cancellation and details of any waiting periods where applicable.

PPS CLAIMS CONTACT DETAILS:

Claims department:
Email: claims@pps.co.za
Fax: 011 644 4520

Claims/General Queries:
Email: memberservices@pps.co.za
Telephone: 011 644 4300