momentum
corporate

Disability / Critical Illness Consent Form

Member to complete this form

1. Scheme details

Scheme name

Employer name

2. Claimant's 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

3. Consent to collect and share personal, health and medical information

Momentum will require the collection of personal, medical and health information in order to assess your disability claim. Momentum will therefore have or come into possession of personal, medical and health related information obtained as a result of your disability claim. It may be that third parties are assisting you with your claim and are liaising with Momentum in relation to your claim.

I hereby consent and authorise:

- any health practitioner (e.g. medical practitioner, dentist, occupational therapist, psychologist, etc.), allied health practitioner, hospital, medical aid, employer, insurance company, health risk management service provider appointed by my employer or any other person who has information about my health, employment related activities and personal information, to provide such information to Momentum or any 3rd party nominated by Momentum who requires this information for the purposes of assessing and managing my claim.
- Momentum to furnish 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, to a health practitioner, allied health practitioner, health risk management service provider appointed by my employer, or any 3rd party nominated by Momentum who may require such information for the purpose of assisting Momentum in the assessment and management of my claim claim or for assessing the payment of a benefit provided for in a risk policy where I am the policyholder.
- Momentum to furnish my employer or its duly appointed intermediary with regular claims status reports which will contain personal information. Momentum will not share any health related information in the status reports unless I have given express written consent.
- Momentum to share all medical and health related information (special personal information) with the following third parties:

☐ Employer (including employer 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 will share medical and health related information with third parties at its sole discretion. I hereby confirm that I will not hold Momentum, its employees, directors, agents, assigns liable in any manner whatsoever and I hereby indemnify and hold Momentum harmless for the sharing of health related information in terms of this consent.

I hereby confirm that I know and understand this consent I am providing to Momentum herein and that I am doing so of my own free will.

Signature of Member

Date D D - M M - 2 0 Y Y

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.

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