Guardrisk INSURANCE
INNOVATIVE RISK SOLUTIONS

CERTIFICATE NO:

CREDIT PROTECTION INSURANCE - TEMPORARY AND PERMANENT DISABILITY

Insured details:

Full name: _____ ID number: _____

Address: _____

Tel no _____ Cell: _____

Email: _____ Fax: _____

Occupation: _____ Employer name: _____

Employer contact detail: _____

Brief description of your normal duties: _____

Claimant details

Full name: _____

Address: _____

Tel no: _____ Cell: _____

Email _____ Fax: _____

Relationship to insured: _____ ID number: _____

Finance detail:

Finance company _____ Account number _____

Vehicle Type _____ Vehicle Registration _____

Date vehicle financed _____ Monthly repayment _____

Details:

Type of disability: _____

Date of disability: _____ Permanent or Temporary

Description of disability: _____

Did the insured have any pre-existing conditions? Y N

If yes, please give detail: _____

Contact detail of doctor in attendance in respect of the disability:

Name and contact detail of usual doctor:

Medical aid scheme and number:

The following documents must be submitted with this claim:

1. Medical certificate to be completed by a qualified and registered medical practitioner selected by Guardrisk at the expense of the insured.
2. Copy of ID
3. Transaction history from finance institute (from inception to date)
4. If motor accident, please attach copy of police report
5. Credit agreement
6. 5 Year medical history before inception of policy

Declaration:

We hereby declare the foregoing particulars to be true in every respect,

I authorize any medical practioner, hospital or other person to provide the appointed agents with any information they may require relating to the medical history for this claim. I agree that this consent shall remain in force at all times, and that a photo-copy or fax of this declaration shall be accepted as the original.

Signature of claimant	Signed on DD/MM/YYYY	Signature of insured	Signed on DD/MM/YYYY

(*Please send this form to: Fax: 086 218 9202 or Email: claims@nttgroup.co.za or PO Box 35302, Menlopark, 0102)*

Office use only

All Premiums paid at date of claim:	Y	N	Comment:	
Assessment of claim assigned to:				