CERTIFICATE NO: ____________

CREDIT PROTECTION INSURANCE - DREAD DISEASE

Insured details:

Full name: ______________________ ID number: ______________________
Address: ____
Tel no ______________________ Cell: ______________________
Email: ______________________ Fax: ______________________

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 illness (please tick)
Heart attack______________ Stroke_______________ Cancer________________ Coronary Artery disease_________________
Renal failure______________ Transplant_______________ Paraplegia_________________ Coma_______________
Serious burns_________________

Date of illness: ______________________
Description of dread disease ____

Did the insured have any pre-existing conditions? | Y | N |
If yes, please give detail: ______________________

Name and contact detail of doctor in attendance of the illness: ______________________

Name and contact detail of usual doctor: ______________________

Medical aid scheme and number: ______________________

Detail of any other insurance you hold: ______________________

The following documents must be submitted with this claim:

1. Medical report 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. Credit agreement
5. 5 Year medical report prior to inception of the product

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:			