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EB2878_E

Claim for Lump sum disability benefit and/or monthly disability income benefit

1 Contents

The following forms and documents must be completed and submitted with a claim for a disability benefit. **Sanlam will only assess the disability claim once in receipt of all the required documentation.**

- **Declaration by fund/scheme**
- **Particulars of the insured's occupation**
- **Declaration by insured**
- **Confidential medical report:** *Report to be compiled by insured's treating specialist according to the guidelines attached. (See page 10).*

The following documents must also be submitted together with the claim forms to Sanlam.

- **Sick leave records:** *Provide copies of all sick leave records for the past 12 months.*
- **Salary statement:** *Please provide a copy of the insured's salary statement as on the last date on which the insured performed his/her duties.*
  In the case of an insured who receives a commission based salary, we require the past 3 year's salary statements.
- **Identity document:** *Please provide a copy of the insured's identity document.*
- **Job description:** *Please provide a copy of the insured's job description.*

2 General

- It is the insured's responsibility to prove that he/she is disabled in terms of the policy provisions.
- The insured has the initial responsibility of providing medical and other documentary evidence of disability at his/her own cost.
- The insured is obliged to submit whatever medical or other information Sanlam may reasonably require.

3 Disclaimer

In line with the FIC Amendment Act, 2017 and other Party Due Diligence requirements, Sanlam has the obligation to identify and verify all persons or entities we interact with. Thus, please provide the information as requested in the forms.

Sanlam reserves the right to cancel the insurance immediately if any of the obligations in terms of the FIC Amendment Act, 2017 and other Party Due Diligence requirements are not met.

The employer must please either post, fax or e-mail the duly completed forms to:

Sanlam Group Risk Benefits: Disability Claims (7709)
PO Box 1
Sanlamhof
Bellville
7532

Fax number (021)947-3207
E-mail address Disabilityclaimbenefits.EB@sanlam.co.za

Declaration by fund/scheme *(To be completed by the employer)*

A Particulars of fund/scheme

Name of fund/scheme _____ Code _____

Name of branch/participating employer _____

E-mail address _____

Telephone number ( ) _____

B Personal details of the insured

Full names and surname _____

Date of birth _____ *(dd/mm/ccyy)* Gender: Male ☐ Female ☐

Marital status Single ☐ Married ☐ Divorced ☐ Co-habiting ☐ Widowed ☐

Identity number _____

Particulars of membership

Membership no. _____ Pay-sheet no. *(If any)* _____

Date of entering service _____ Date of permanent appointment

Date of commencement of membership _____

If the scheme has been underwritten by Sanlam for less than one year, please complete the following:

Type of benefit and cover the insured enjoyed at the previous insurer.

Type of benefit _____ Cover amount R _____

Provide the date from when the insured was covered at the previous insurer? _____

Salary information for the past 3 years

Date of salary received *(dd/mm/ccyy)*	Annual salary (R)*	Annual cost to company salary (R)

***** *This must be the salary on which the premiums paid to Sanlam, are calculated.*

C Medical Aid Premium Waiver benefit

Note: *The following information must only be provided if the policy makes provision for the benefit and if a claim for the Medical Aid Premium Waiver Benefit must be considered with the disability of the insured.*

Name of insured's medical aid scheme _____

Particulars of dependants	Name and surname	Date of birth *(dd/mm/ccyy)*	Amount of medical aid premium * (R)
Principle member			
Spouse			
Child (1)			
Child (2)			
Child (3)			
Child (4)			

* including the premium for the savings account and any unborn child if pregnancy is in second or third trimester.

Important: *Please inform Sanlam in case any of the information supplied with regard to the Medical Aid Premium Waiver Benefit changes.*

We, the undersigned, declare on behalf of the fund/scheme that the information provided above is complete and correct.

Signed on behalf of the fund/scheme

Initials and surname _____

Designation _____

Signature _____

Place _____

Date _____ *(dd/mm/ccyy)*

Particulars of insured's occupation

Note: *This section must be completed in consultation with the insured's manager, supervisor or any other person who is familiar with the circumstances.*

Name of supervisor _____

Telephone number of supervisor ( ) _____

Name of contact person at Human Resources Department _____

Telephone number of contact person ( ) _____

Insured's occupation _____

Please list the insured's main duties:

Duty	Weight (%)	Present ability to perform duties		
		Able	Partially able	Unable
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
	100%			

Please list the insured's job demands and job category in current occupation

Job demands	%
Physical	
Supervisory	
Administrative	
Total	100%

Job category	
Manager	☐
Supervisor	☐
Clerical	☐
Machine operator	☐
Light manual labourer	☐
Heavy manual labourer	☐
Other:	

Please list the physical aspects of the occupation

Movement	%Time spend				Comments
	None	Occasionally 0-33%	Frequently 34-67%	Majority 68-100%	
Weight handling:	☐	☐	☐	☐	Maximum weight:
- Lift	☐	☐	☐	☐	Maximum weight: Kilogram
- Carry	☐	☐	☐	☐	Maximum weight: Kilogram
- Push or pull	☐	☐	☐	☐	Maximum weight: Kilogram
- Throw	☐	☐	☐	☐	Maximum weight: Kilogram
Standing	☐	☐	☐	☐	
Walking	☐	☐	☐	☐	
Climbing:	☐	☐	☐	☐	
- Stairs	☐	☐	☐	☐	
- Ladders	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	
Crawling	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	
Fine precision work	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

Particulars of insured's occupation *(continued)*

How often does the insured work in the following conditions?

Work conditions	How often?	Work conditions	How often?
Indoors		Dust	
Outdoors		Vibration	
High areas		Noise	
Underground		Fumes	
Wet areas		Extreme heat	
Cold storage areas		Walking on uneven surfaces	
Driving a vehicle		Operate machinery	
Type of vehicle:		Estimate distance covered per day/week/month	

Last date of performing his/her duties _____ *(dd/mm/ccyy)*

Did he/she do other work thereafter? Yes ☐ No ☐

If "Yes", provide the following particulars:

In which capacity? _____

Description of work _____

From which date? _____ Until which date? _____

Educational qualification of insured _____

Further training courses completed _____

_____

_____

Was the insured considered for any other position in the organisation? Yes ☐ No ☐

If "Yes", please answer the following questions.

In what capacity? _____

Is the status of the position: Higher ☐ Equal ☐ Lower ☐ than the previous position?

Average remuneration per month in this position: R _____

Did the insured accept the position? Yes ☐ No ☐

If not, please provide reasons: _____

_____

If insured could not be considered/placed elsewhere, please give reasons:

_____

_____

_____

Signed on behalf of the fund/scheme, *(insured's manager, supervisor or any other person who is familiar with the circumstances).*

Initials and surname _____

Designation _____

Signature _____

Place _____

Date _____ *(dd/mm/ccyy)*

Disability Claim: Declaration by insured *(To be completed by the insured)*

Surname _____

Full names _____

Previous name *(if applicable)* _____

Date of birth _____ *(dd/mm/ccyy)* Gender Male ☐ Female ☐

Country of birth _____

Type of identification Identity document* ☐ Passport ☐ *copy of applicable document compulsory*

Number _____ Country of issue _____

Passport expiry date _____ *(dd/mm/ccyy)*

**Provide a copy of your Identification document or Identification Smart card (copies of both sides)*

Country and/or Country of citizenship/Nationality RSA ☐ Other country Yes* ☐ No ☐

* If "Yes", please give other country _____

Address and contact numbers

Residential address _____

_____ Postal/Zip code _____

Postal address *(if it differ from the residential address)* _____

_____ Postal/Zip code _____

e-mail address _____

Cell/Mobile _____ Other contact number (h) _____ (w) _____

1(a) Educational History

Highest school qualification _____

Other training/qualifications _____

_____

_____

1(b) Occupational history

- Please give a detailed description of your career history, including your present occupation. The exact date(s) on which service commenced and was terminated, are required:

Name and address of employer	Period in service / From *(dd/mm/ccyy)*	Period in service/ To *(dd/mm/ccyy)*	Nature of work

- Please describe the most important functions of your occupation directly before disablement.

_____

_____

_____

_____

_____

1(b) Occupational history *(continued)*

- What illness, injury or impairment caused your inability to work?

- Please describe the symptoms you are experiencing and how it affects your ability to work.

- On what date did you last actively practice your occupation? _____ *(dd/mm/ccyy)*
- Have you been able to perform any other occupations or functions since you first became disabled?

- Based on your experience and training, what other occupations can you perform?

2 Nature of disability and medical care

- If your disability was caused by an accident, please give the following information:
  - Circumstances causing the accident.

  - If a formal enquiry was conducted, please state by whom and what the result was.

  - Date of accident _____ *(dd/mm/ccyy)*
- Since what date did you experience the symptoms? _____ *(dd/mm/ccyy)*
- On what date did you see the doctor about this for the first time? _____ *(dd/mm/ccyy)*
- Provide the names and contact details of doctors/specialists/therapists consulted in this regard and provide details:

Name of doctor(s)/specialists/therapist consulted	Profession	Contact number(s)	e-mail address

- How do you spend your days?

- Which activities (not work related) can you <u>not</u> perform as a result of your illness, injury or impairment?

3 Income

Are you receiving or do you expect to receive, any benefit, salary, pension or compensation of whatever nature as a result of or during your disability? *(Including income from any employer, partner, assurance company, a pension or retirement annuity fund, any governmental fund or any other source.)* Yes ☐ No ☐

- If "Yes", please give the following details:

Regular amounts *(Including Life annuities)*

Source of benefit	Amount (R)	Commencement date of payment *(dd/mm/ccyy)*	Date of cessation *(dd/mm/ccyy)*

Disability amounts included in ordinary assurance at any other companies *(Regardless of whether claim has been submitted already)*

Name of company	Amount (R)	Date of payment *(dd/mm/ccyy)*

Tax particulars

Income tax reference number _____

Income tax office to which last return was rendered _____

4. Banking details

Please provide us with a copy of a bank statement not older than three months as well as the following information:

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current ☐ Savings ☐ Transmission ☐

5 Disclaimer

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6 Consent for Disclosure of Confidential Information and Declaration

I, _____ *(full name(s) and surname of insured)*

Identity number _____ hereby grant my voluntary and informed consent to medical practitioners to disclose my medical and personal records to the medical practitioners appointed by the insurer to assess my disability.

This includes my previous medical history as well as any psychological or psychiatric records for the purpose of determining my ability to perform my work.

I also declare that I have no objections to medical information being supplied to the medical advisor of Sanlam, the Reinsurers, and from and to the medical service providers involved in the disability assessment and rehabilitation processes for the consideration of any claim for benefits under a policy.

I also irrevocably authorise any doctor or other person who may be in possession of or who may later obtain possession of any information regarding my health, whether such information pertains to the past or to the future, to disclose such information to Sanlam and I agree that this authorisation will also remain in force even after my death.

I declare that I am the person described above and that the replies given to the questions are true and correct.

Completed and signed at _____ on this _____ day of _____ 20 _____

Signature of insured _____

Full name(s) and surname of witness _____

Signature of witness _____

Guidelines for a confidential medical report

Important: The examination and compiling of a medical report must be done by the patient's treating specialist and cannot be performed by a general practitioner.

Dear Doctor,

Sanlam is in the process of assessing the extent of the patient's disabilities, in view of a claim for disability benefits. To assist us in making a justified decision, we require a report regarding the functional impairment of the patient.

The assessment of a disability claim is based on the principals of **functional impairment** and **disability**. It is important that you are aware of our distinction between the two principles.

- **Functional impairment** is determined by using a medical diagnosis of the functions a person is able to perform and the functions that can no longer be performed.
- **Disability** is determined through a legal process that assesses the extent of a person's functional impairment, judged in conjunction with his/her job description, the policy conditions and personal factors such as education, experience, etc. (This decision will be made by Sanlam Life Insurance Ltd.)

Kindly supply Sanlam with a report, along the guidelines provided below, after you have examined and assessed the **functional impairment** of the patient.

Please note that the patient's identity needs to be established above doubt before proceeding with the examination. Confirm the document /means used to establish the patient's identity, in your report.

Any costs relating to this consultation and medical report, is for the patient's account. Should you require additional test / evaluations to establish the patient's functional impairment, the patient will also be responsible for settling these.

Guidelines for a medical report on functional impairment

- Diagnosis (DSM IV for psychiatric conditions)
- Date of onset and course of disease
- Severity Perpetual factors, secondary gain
- Current clinical findings. Detailed description
- Treatment
  - Treatment modalities
  - Types of medication and dosage
  - Duration of treatment
  - Therapeutic procedures
  - Rehabilitation
  - Hospitalisation
- Response to treatment
- Complications that are permanent
- Special investigations (e.g. ECG, X-rays, scans)
- Prognosis with optimal treatment
- Influence on lifestyle, activities of daily living and working capability
- Special requirements
  - Cardiovascular: NYHA classification, exercise capacity, stress ECG, ejection fraction, other
  - Respiratory: dyspnea-grading(ATS),exercise capacity,(METS or VO2 max.) vitalogram pre-and post-inhalation (3 attempts), chest X-ray, single-breath diffusion test (Dco) in cases of interstitial lung disease
  - Orthopaedic: X-ray and stress views, MRI or CAT scans, other (eg. nerve conduction tests)
  - Psychiatric: social functioning, concentration, psychometric tests in cases of cognitive impairment