DISABILITY CLAIM FORM – CLAIMANT & EMPLOYER

Please return to: Hollard Group Risk, 1st Floor, 34 Melrose Boulevard, Melrose Arch or Postnet Suite 196, Private Bag X1, Melrose Arch, 2076
Tel: (011) 351 5000. Fax: (011) 351 3079 Email: hgrdisability@hollard.co.za

SECTION A: HOW TO CLAIM

Two forms are required for the submission of a disability claim.

1. DISABILITY CLAIM FORM – CLAIMANT & EMPLOYER (to be completed by the claimant and the employer)
2. DISABILITY CLAIM FORM – MEDICAL ATTENDANT'S REPORT (to be completed by the claimant/employer and the medical attendant)

The claimant must obtain at his/her own expense, the medical attendant's report from a registered medical practitioner, who is not a member of the claimant's immediate family.

In the event that the claimant is incapacitated, the sections to be completed by the claimant must be completed by the claimant's caretaker and/or the employer. We require an affidavit confirming the claimant's inability to complete and sign the claimant's personal declaration.

It is essential that both forms are fully completed to prevent any unnecessary delays due to missing or incomplete information.

It is the employer's responsibility to compile all the documents required and to submit them to Hollard. If we ask for an original certified copy of a document we will not accept a certified copy of a previously certified copy.

This form is structured in twelve sections:

- Section A: How to claim (informative section)

To be completed by either claimant or employer or both:

- Section B: Policy details
- Section C: Employer's details
- Section D: Claimant's personal details
- Section E: Claimant's report on Education and Training (to be completed by the claimant)

To be completed by claimant:

- Section F: Claimant's report on employment
- Section G: Claimant's report on claim
- Section H: Declaration

To be completed by employer:

- Section I: Employer's report
- Section J: Declaration

To be completed jointly by the claimant and the employer:

- Section K: Occupational information
- Section L: Declaration

This fully completed form should be accompanied by the following supporting documentation:

- an original certified copy of the claimant's identity document
- a copy of the claimant's pay slip for the month of Disability
- a copy of the claimant's job description
- a copy of the claimant's sick leave records
- copies of any medical certificates on file with the employer

- proof of continuous premium payment during the waiting period
- proof of employer banking details (cancelled cheque or bank statement)
- accident report form from the South African Police Services (if applicable)
- accident report required by COID (if applicable)

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Life.

PRIVACY

We respect the confidentiality of your personal and medical information as well as your privacy. If necessary, we may need to share either your and/or the insured's personal or medical information, or both, with third parties. These third parties are other insurance and/or reinsurance companies, or service providers that may assist us in assessing and managing the risk or servicing you. We impose the same strict confidentiality standards on these third parties as is applied by us. By providing the required personal and medical information, and signing this form, you hereby confirm that you consent to us processing and sharing your and/or the disabled person's personal and medical information with other third parties. We will treat this information with caution and we have put reasonable security measures in place to protect it. The information provided will only be used for its intended purpose and will not be shared within the Hollard Group or another organisation for marketing additional products and/or services to you.

SECTION B: POLICY DETAILS

Employer:

Policyholder:

Policy number:

Membership / Employee number:

SECTION C: EMPLOYER'S DETAILS

Name of company:

Physical address:

Postal address:

Code:

Contact person:

Job title:

Telephone number:

Fax number:

E-mail address:

SECTION D: CLAIMANT'S PERSONAL DETAILS (to be completed by employer or claimant)

First names:

Surname:

Identity number:

Date of birth: DDMMYYYY

Gender: M F

Residential address:

Code:

Postal address:

Code:

Home telephone number:

Cell phone number:

Email address:

Occupation:

Tax Reference number:

SECTION E: CLAIMANTS REPORT ON EDUCATION AND TRAINING (to be completed by claimant)

1. What was the highest level of education that you received?

2. Please give details of formal training, qualifications and any courses which you attended during your working career

Date From	Date To	Name of Employer, College or Institution	Qualifications obtained	Brief Description of Course content

SECTION F: CLAIMANT'S REPORT ON EMPLOYMENT (to be completed by the claimant)

1. What is your current position?

2. When did you start in your current position? DDMMYYYY

3. When were you last able to perform fully in your current position? DDMMYYYY

4. When did you stop working? DDMMYYYY

5. Are you still receiving a salary? Y N

If "No", when did you receive your last salary? DDMMYYYY

6. Have you been able to perform any of your main occupational duties since the onset of your condition? Y N

If "Yes", please provide details, including dates, and a description of your occupational duties and remuneration

7. Have you been able to perform in any other occupation since the onset of your condition? Y N

If "Yes", please provide details, including dates, and a description of your occupational duties and remuneration.

8. When do you expect to be able to resume work on a:

(a) Part-time basis? DDMMYYYY

(b) Full-time basis? DDMMYYYY

9. Apart from your current position, please supply a history of previous positions held with your current and previous employers.

From	To	Company	Position held	Type of work done	Reason for change

SECTION G: CLAIMANT'S REPORT ON CLAIM (to be completed by the claimant)

1. What do you understand to be wrong with you?

2. When did you first experience symptoms relating to this condition? DDMMYYYY

Please describe these symptoms

3. Has any of the following contributed in any way to your condition?

Nature of contributor			Details
Accident (If "Yes", please complete number 4 below)	Y	N	
HIV:	Y	N	
Previous illness or injury:	Y	N	
Hazardous pursuit or pastime:	Y	N	
Habits e.g. excessive alcohol consumption:	Y	N	
Self-inflicted injuries	Y	N	

4. If this claim has arisen from an accident please answer the questions below.

The accident occurred at (place):

On (date): DDMMYYYY At (time): hhmm H

The accident occurred at (place):

Name of Police Station where accident was reported

The SA Police case number:

Describe fully how the accident happened:

5. When did you first consult a medical practitioner in respect of your current condition?

DDMMYYYY

6. Please provide details of the first medical practitioner consulted:

Name:

Telephone number:

Fax number:

Address:

Code:

7. Name, address and telephone number of your usual family doctor:

Name:

Telephone number:

Fax number:

Address:

Code:

8. Provide names, addresses and telephone numbers of all other medical practitioners including specialists consulted in connection with this condition.

Name:

Type of practice:

Address:

Code:

Telephone number:

Name:

Type of practice:

Address:

Code:

Telephone number:

Name:

Type of practice:

Address:

Code:

Telephone number:

9. Have you ever suffered from any other form of impairment or ever been declared disabled from employment before? Y N

If "Yes", please provide details:

10. Have you been referred to any health care professionals e.g. Physiotherapist, Occupational Therapist, Psychologist or other medical specialists? Y N

If "Yes", please provide details:

Name	Type of Practice/ Specialty	From	To	Treatment & Outcome

11. Have you had any tests, X-rays or special investigations relating to your condition or any other impairment? Y N

If "Yes", please provide details:

Date	Doctor/hospital	Investigation	Done	Outcome

12. (a) How has your condition been treated?

Date	Therapy / Medication	Description / Dosage

(b) Is future surgery planned / required / anticipated? Y N

If "Yes", please advise when and provide description:

13. Has there been any improvement in your condition? Y N

If "Yes", please provide details.

14. How has this condition affected your ability to perform your activities of daily living?

Activity	Description	Can/With help/Cannot
Washing	The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.	
Mobility	The ability to move indoors from room to room on level surfaces.	
Transferring	The ability to move from a bed to an upright chair or wheelchair and *vice versa.*	
Dressing	The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	
Eating	The ability to feed oneself once food has been prepared and made available.	
Toileting	The ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate. The maintenance of continence is included in this activity of daily living although it may be regarded as an activity of daily living on its own.	

15. Please provide full details of your current daily activities.

16. Have you resided outside South Africa in the past year?

If "Yes", please provide details:

From	To	Country	Reason

17. Do you intend to reside outside South Africa?

If "Yes", please provide details:

From	To	Country	Reason

18. Please provide details of any benefit, salary or remuneration that you have received or expect to receive as a result of your incapacity including details of salary, benefits from an insurance company, pension fund, state fund or any other source.

Source of benefit	**Name of company and your reference number**	**Amount**
Monthly disability benefit		
Salary		
Commission		
Other employer earnings		
Pension		
COID/ WCA benefits		
Other insurance benefits		
Other source 1		
Other source 2		

SECTION H: DECLARATION (to be signed and dated by claimant)

I, _____ hereby declare that I am the person insured under the policy mentioned above.

The answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard. I agree that all the written statements, reports and affidavits submitted in support of this claim shall constitute part of this claim.

I agree that benefits payable in respect of this claim shall be forfeited if I, or any person acting on my behalf with my consent, have withheld any material fact or submitted any false information in respect of this claim, and that Hollard Life reserves the right to proceed with the appropriate action against the claimant as well as any beneficiary or third party that received a benefit (if applicable).

Accepting that I am thereby limiting my right of privacy, but to assist with the assessment of my claim I irrevocably authorise Hollard Life:

a) to obtain from any person, whom I hereby so authorise and request to give, any information which Hollard Life deems necessary, and
b) to share with other insurers that information and any information contained in this claim form or in any related document, either directly or through a data base operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Hollard Life or by the operators of such data base.

I authorise any medical practitioner, hospital or other person to provide Hollard Life with any information Hollard Life may require relating to my medical history, my injury, my employment history and/or any other information which may be necessary for Hollard Life's consideration of the claim. I also provide consent that any information provided by me may be verified against other sources or data bases including credit bureaus. Furthermore I have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information. If I am agreeing to the aforementioned on behalf of someone else, I confirm that I have the necessary approval and/or mandate to do so.

Signed at _____ on this _____ day of _____ 20 _____

Claimant's name

Signature

In the event that the form was completed on behalf of the claimant:

Caretaker's name

Signature

SECTION I: EMPLOYER'S REPORT (to be completed by the employer)

1. When did the claimant join the company? DDMMYYYY

2. When did the claimant join the disability benefit scheme? DDMMYYYY

3. Is the claimant a full-time employee? Y N

4. Date appointed as full-time employee? DDMMYYYY

5. Month last risk premium was paid for? MMYYYY

6. What was the claimant's salary as at the date that the claimant was no longer able to fulfill the requirements of his/her occupation?

7. What was the effective date of this salary? DDMMYYYY

8. Is the claimant still receiving a salary? Y N

If "Yes", what is the current salary amount?

If different from the salary declared in number 8, please advise from which date this new salary was applicable and reason for the difference?

Reason: Date: DDMMYYYY

Until what date do you intend to pay the claimant this salary? DDMMYYYY

9. When was the claimant last able to perform his/her duties in full? DDMMYYYY

10. Is the claimant still working? Y N

If "Yes", please provide details of current activities:

11. When do you expect the claimant to resume work on a:

(a) Part-time basis? DDMMYYYY

(b) Full-time basis? DDMMYYYY

12.What do you understand to be affecting the claimant's ability to perform the duties of his/her current occupation?

13. How is the performance of the claimant's occupational duties being affected by his/her condition?

14. What accommodations or adaptation can you make within the company to keep the claimant at work?

15. Have any steps been taken to assist the claimant to continue to work within the company? Y N

Please provide details

16. If this claim has arisen from an accident at work please answer the questions below.

The accident occurred at (place):

On (date): DDMMYYYY At (time): hhmm h

Please provide a brief description of your understanding of how the accident happened?

17. Please provide details of any benefit, salary or remuneration received by the claimant from whatever source (e.g. from you the employer, an insurance company, a fund or any other source).

Source of benefit	**Name of company and your reference number**	**Amount**
Monthly disability benefit		
Salary		
Commission		
Other employer earnings		
Pension		
COID/ WCA benefits		
Other insurance benefits		
Other source 1		
Other source 2		

SECTION J: DECLARATION (to be signed and dated by the employer)

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life. In the event that this claim or any supporting claim documentation is found to be fraudulent or misrepresented, Hollard Life reserves the right to proceed with the appropriate action against the claimant.

I have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information. If I am agreeing to the aforementioned on behalf of someone else, I confirm that I have the necessary approval and/or mandate to do so.

Signed at ____ on this ____ day of ____ 20 ____

Name and Surname of authorised signatory who warrants his/her authority to sign on behalf of the policyholder

Designation

Signature
For and on behalf of the policyholder

Company Stamp

Identity Number of authorised signatory:

Telephone number of authorised signatory:

Email address of authorised signatory:

SECTION K: OCCUPATIONAL INFORMATION (to be completed jointly by the employer and the claimant)

1. Please state the claimant's current job title or position held?

2. Is the claimant responsible for the supervision of any staff? Y N

   If "Yes", please state number of staff supervised:

3. Apart from your present occupation, please provide a brief job history, including previous positions held within the company.

From	To	Position held	Type of work done

4. Please provide details of formal training and any courses you attended with the current employer.

From	To	College or institution	Nature of training	Grade/Standard achieved

5. Please select the job category that would be most applicable to your position.

- ☐ Managerial
- ☐ Supervisory
- ☐ Clerical
- ☐ Machine operator (e.g. driving or using a machine to perform a task)
- ☐ Light manual labour (e.g. physically packing or sorting)
- ☐ Heavy manual labour (e.g. physically digging or loading)
- ☐ Other (Please provide description in the space provided below)

6. Please provide a brief summary of your main duties in your role?

7. What is the minimum training /education required to perform the claimant's occupation?

School		Standard	
Technical		Diploma	
Professional		Degree	
On the job training		Months	

Other:

8. Please complete the questions below on the claimant's work environment.

8.1 Please describe the work conditions (e.g. metres, percentages, hours or actual descriptions):

Work Conditions	Yes	Details	Work Conditions	Yes	Details
Indoor	☐		Outdoor	☐	
Vibration	☐		Noise	☐	
Height	☐		Depth	☐	
Humid/Cold temperatures	☐		Wet	☐	
Rough Terrain	☐		Smooth Terrain	☐	
Underground	☐		Fumes	☐	
Balance Required	☐		Dry	☐	
Dust	☐		Other	☐	

8.2 Please provide the details of any known safety hazards in the claimant's occupational duties:

9. What are the daily standard working hours?

Week: Start time ☐ End time ☐ **Week-end:** Start time ☐ End time ☐

10. Is shift work required?

Y N

If "Yes", please provide details of alternate shift times:

11. Please complete the below on the physical demands of the claimant's occupation:

Activity	Never	Sometimes	Often	Always	Hours per day
Sitting					
Kneeling					
Standing					
Bending					
Climbing					
Walking on even terrain					
Walking on uneven terrain					
Use of both hands					
Use of fine coordination					
Lifting weights					
Carrying weights					
Pushing weights					
Engaging in physical labour					
Reaching above shoulder height					
Working in cramped conditions					

12. What hand tools, machines, materials and equipment are used to perform the claimant's occupational duties?

13. Please describe the minimum mental abilities that a healthy individual requires to perform the claimant's occupational duties by completing the table below.

Abilities required	Very often	Often	Seldom	Examples of tasks requiring these abilities
Literacy				
Numeracy				
Memory				
Problem solving				
Decision making				
Specialised knowledge				
Concentration				
Planning				
Calculations				
Administrative tasks				

14. Please describe the minimum communication skills required to perform the claimant's occupational duties by completing the table below.

Communication Skills required	Very often	Often	Seldom	Aspects of occupational duties requiring these communication skills
Speaking				
Writing				
Listening				
Reading				
Public speaking				

15. Only complete this question if driving is a component of your occupational duties.

Licence code(s) required:

Type of vehicle(s) driven:

Average distance driven: per day Km per week Km per month Km

16. Only complete this question if flying is a component of your occupational duties.

Type of aircraft flown:

Average distance flown per week: Km Average number of hours flown per week:

17. Only complete this question if diving is a component of your occupational duties.

Certification:

Average depth per week: Km Average number of dives per week:

Are any mixed gasses used:

18. Only complete this question if mining is a component of your occupational duties.

Certification:

Are you involved with blasting or explosives? Y N

If yes, please provide details of how you are involved and how often:

What type of mining is undertaken? Opencast Underground

If "Underground", please advise:

How often do you go underground:

Average number of hours spent underground per week:

What activities are performed whilst underground:

19. Only complete this question if going out to sea is a component of your occupational duties.

Seamen's licence:

How often: How long:

What activities are performed whilst out at sea:

SECTION L: DECLARATION (to be signed and dated by both the employer and the claimant)

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life. In the event that this claim or any supporting claim documentation is found to be fraudulent or misrepresented, Hollard Life reserves the right to proceed with the appropriate action against the claimant.

I have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information. If I am agreeing to the aforementioned on behalf of someone else, I confirm that I have the necessary approval and/or mandate to do so.

Signed at ____ on this ____ day of ____ 20 ____

Name of authorised signatory

Designation

Signature
For and on behalf of the employer

Company stamp

Identity Number of authorised signatory:

Telephone number of authorised signatory:

Email address of authorised signatory:

Signed at ____ on this ____ day of ____ 20 ____

Claimant's name

Signature

In the event that the form was completed on behalf of the claimant:

Caretaker's name

Signature

Identity Number of Caretaker:

Telephone number of Caretaker:

Email address of Caretaker:

OR

Name and Surname of authorised signatory who warrants
His/her authority to sign on behalf of the employer:

Signature

Identity Number of authorised signatory:

Designation of authorised signatory:

Telephone number of authorised signatory:

Email address of authorised signatory:

Hollard is committed to "Creating and securing a better future" and therefore subscribes to an internal Anti-Fraud policy. Please report any suspicious or unethical activity anonymously on 0801 516 170 (toll free) or via email at Hollard@tip-offs.com.