Sanlam

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

Employer / Fund Name		Scheme Code	

Important Information

- **It is important that you complete the forms in full. The answers you provide will help us understand the illness/injury that is causing the absence from the workplace and will help to avoid delays in the processing of the claim.**
- It is the employee's responsibility to prove that they are disabled in terms of the policy provisions.
- The employee has the initial responsibility of providing medical and other documentary evidence of disability at their own cost.
- The employee is obliged to submit whatever medical or other information Sanlam may reasonably require.
- Sanlam reserves the right to have the employee examined by a specialist that we have chosen, before admitting a claim, provided that the employee submits mandatory medical information to prove their disability.
- **The employer must either post or e-mail the completed forms to:**

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

E-mail address:
sgrdisabilityclaims@sanlam.co.za

	Forms and documents required (Sanlam can only assess the disability claim once all the relevant *fully* completed forms and documents have been received)	Who completes the Form
☐	**Declaration by employer**	**Employer**
☐	**Particulars of the Employee's occupation**	**Employer**
☐	**Declaration by Member or Employee**	**Employee**
☐	**Confidential medical report** *Attached Confidential Medical Report to be completed by employee's treating specialist (or general practitioner, if no specialist is treating the employee). Form EB2880E attached. If the doctor provides a typed report, the guidelines on page 12 apply.*	**Employee's Doctor**
☐	**Leave records: Please provide copies of all leave records for the past 12 months.** *Sick leave should be clearly marked*	**Employer**
☐	**Salary statement: Please provide a copy of the employee's salary statement as on the last date on which the employee performed their duties.** *In the case of an employee who receives a commission-based salary, we require the past 3 year's salary statements.*	**Employer**
☐	**Copy of employee's identity document**	**Employee**
☐	**Job description.** *Please provide a comprehensive (typed) copy of the employee's job description at the time of disability.*	**Employer**

Sanlam Corporate: Group Risk

Please return the completed form and supporting documents to:
sgrdisabilityclaims@sanlam.co.za

1. Details of the Employer	
Name of Employer	
Name of Employer Representative	
Address of Employer	
E-mail address of Employer Representative	
Telephone number	

2. Details of the Employee			
First name(s)			
Surname			
Gender			
Employee Number			
RSA identity number*	*Compulsory	Date of birth	*(dd/mm/yyyy)*
If not RSA, passport number*	*Compulsory	Passport expiry date	*(dd/mm/yyyy)*
Current Occupation			
Date of permanent employment			
Last date of performing duties			
Highest Educational qualifications			
Further courses / training completed			

Salary information for the past 3 years (*Annual salary is the salary on which premiums paid to Sanlam are calculated)

Date salary received	Annual salary (R)*	Annual cost to company salary (R)	Company increases (%)
(dd/mm/yyyy)	**R**	**R**	0.00%
(dd/mm/yyyy)	**R**	**R**	0.00%
(dd/mm/yyyy)	**R**	**R**	0.00%

3. Medical Aid	
Name of employee's medical aid scheme	
Medical Aid Plan name	
Medical Aid scheme number	

4. Details of the employee's occupation

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

Name of supervisor			
Supervisor e-mail address		Telephone number	
Name of Human Resources contact person			
Human Resources e-mail address		Telephone number	
Employee's Occupation or Job			

Prior to their current work absence, how much time has the employee been off work due to sickness in the past 12 months?

Please state approximate number of days / weeks:	days		weeks	

Please list the employee's main duties below:

Task	Weight (%)	Current ability to perform tasks		
		Able	Partially able	Unable
e.g. Filing	80%			
	0%			
	0%			
	0%			
	0%			
	0%			
	100%			

Please list the employee's job demands and job category in their current occupation below:

Job demands	%
Physical	0%
Supervisory	0%
Administrative	0%
Total:	**100%**

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

Please list the physical aspects of the occupation below:

Movement	% Time spend				Comments
	None	Occasionally 0-33%	Frequently 34-67%	Majority 68-100%	
Weight handling:					*Please complete the maximum weight in kg for all weight handling categories.*
• Lift					**kg**
• Carry					**kg**
• Push or pull					**kg**
• Throw					**kg**
Standing					
Walking					
Climbing:					
• Stairs					
• Ladders					
Bending					
Kneeling					
Crawling					
Sitting					
Fine precision work					
Other					

How often does the employee work in the conditions below?

Work conditions	How Often - No. of hours	Work conditions	How often – No. of hours
Indoors		Dust	
Outdoors		Vibration	
High areas		Noise	
Underground		Fumes (gas, etc.)	
Wet areas		Chemical exposures	
Cold storage areas		Extreme heat	
Confined spaces		Walking on uneven surfaces	
Driving a vehicle		Operating machinery	
Type of vehicle:		Estimate distance covered per day/week/month	
Hybrid work — Days at workplace:		Days working from home:	
Last day of performing their duties:			*(dd/mm/yyyy)*

What is your current employment status?

Working full time		Working part time		On sick leave	
On unpaid leave		Retrenched		Dismissed	

Has a date been discussed/agreed for the employee to return to work?			Yes	No
If Yes, please provide details:				
How often are you in contact with the employee?				
Was the employee considered for any other position in the organisation?			Yes	
If Yes, provide the following information below:				
In which role?				
Description of work i.e. Office or reduced hours				
Accommodated work duties:				
Please provide a description of the accommodated duties:				
Working hours		Working environment		
From which date?	*(dd/mm/yyyy)*	Until which date?	*(dd/mm/yyyy)*	
Is the status of the position: Higher	Equal	Lower	than the previous position?	
Average remuneration per month in this position:			**R**	
Did the employee accept the position?			Yes	No
If No, please provide reasons:				
If the employee could not be considered / placed elsewhere, please give reasons:				
Were or are there any other factors or reasons impacting on the employee's absence- e.g. workplace issues, disciplinary, family circumstance, etc.?			Yes	No
If Yes, please provide brief details:				

Signed by the employer on behalf of the fund/scheme			
We, the undersigned, declare on behalf of the fund/scheme that the information provided above is complete and correct.			
Signature *(on behalf of scheme / HR)*		**Signature** (*the employee's manager, supervisor or any other person who is familiar with the circumstances)*	
Initials and surname		Initials and surname	
Designation		Designation	
Date	*(dd/mm/yyyy)*	Place	

DISABILITY CLAIM

SECTION B: Declaration by Employee (Compulsory, must be completed by the employee)

1. Personal details of the employee					
First name(s)					
Surname					
RSA identity number*					
If not RSA, passport number*	*Compulsory		Country of issue*		*Compulsory
Passport expiry date	*Compulsory				
Nationality	RSA		Other *(please state country)*		
Date of birth	*(dd/mm/yyyy)*		Country of birth		
Residential address					
				Postal code	
Postal address *(if different)*				Postal code	
E-mail address *(Work)*					
E-mail address *(Preferred address)*					
Cell phone number					

2. Alternative Contact Information (in case we are unable to reach you)			
First name(s)			
Surname			
Relation			
Cell phone number		E-mail address	

3. Educational and Occupational history	
Highest school qualification	
Other training/qualifications	

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	Period in service to	Nature of work
	(dd/mm/yyyy)	*(dd/mm/yyyy)*	
	(dd/mm/yyyy)	*(dd/mm/yyyy)*	
	(dd/mm/yyyy)	*(dd/mm/yyyy)*	
	(dd/mm/yyyy)	*(dd/mm/yyyy)*	

Please describe the most important tasks of your occupation directly before disablement:

4. Impact of your condition on your job

Please describe the symptoms you are experiencing, including how often and how it affects your ability to work:							
Since when have you been experiencing difficulties performing your duties due to your illness?						*(dd/mm/yyyy)*	
On what date did you last actively performed your current job?						*(dd/mm/yyyy)*	
Have you been able to perform any other occupations or tasks since you first became ill or injured?					Yes		No
If Yes, please describe these tasks:							
I do think I will be back to my normal work within 6 months.							
Strongly agree		Agree		Disagree		Strongly disagree	
What would need to change, and what assistance would you need, for you to return to work?							
Please also advise whether you have discussed the above with your employer:					Yes		No
Based on your experience and training, what other occupations can you perform?							
It is important to me to go back to work in the future.							
Yes		Only when I recover		Maybe		Not at all	
I am afraid that going back to work will worsen my health condition.							
Yes		No		Prefer not to say			

5. Medical treatment received

What is the medical condition related to your claim?			
When did you first experience the symptoms?		*(dd/mm/yyyy)*	
When did you see the doctor for the first time regarding these symptoms?		*(dd/mm/yyyy)*	
How many times have you seen your General Practitioner (GP)/main treating doctor in the past 12 months (for your own health)? Please state approximate number of visits:			
Access to health care	Public health care		Private health care
What treatment have you received *(include treatment type and frequency):*			
Are you using any assistive devices / technology *(hearing aids, walking aids, etc.)*			

Please provide us with a list of your current medication and dosages:

Medication	Dosage

Do you suffer from any other medical conditions? Yes ☐ No ☐

If Yes, please provide details:

Provide the names and contact details of doctors/specialists/therapists consulted in this regard:

Name of doctor / specialist / therapist consulted	Profession	Contact number	E-mail address

How are you coping with this illness/injury?

I'm coping very well ☐ I'm coping well ☐ I'm not coping so well ☐ I'm not coping at all ☐

How do you spend your days?

I have people (family, friends, neighbours, colleagues and/or others) who I can count on when I need help or support.

Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree ☐

6. Disability due to an accident (include a copy of the accident report)

If your disability was caused by an accident, please give the following information:

Circumstances causing the accident:

Date of accident *(dd/mm/yyyy)*

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

7. Income

When did you last receive a salary from your employer?	(dd/mm/yyyy)

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 Illness or injury? *(Including income from any employer, partner, assurance company, a pension or retirement annuity fund, RAF, COIDA, 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	Commencement date	Date of cessation
	R	(dd/mm/yyyy)	(dd/mm/yyyy)
	R	(dd/mm/yyyy)	(dd/mm/yyyy)

Disability amounts included in insurance at any other insurer *(regardless whether a claim has been submitted).*

Name of insurer	Amount	Date of payment
	R	(dd/mm/yyyy)
	R	(dd/mm/yyyy)
	R	(dd/mm/yyyy)
	R	(dd/mm/yyyy)
Income tax reference number		

Do you perform any other work for income?	Yes	No

If Yes, please describe in detail:

Do you have any businesses registered in your name?	Yes	No

If Yes, please complete the following:

Name of business	Type of business	Annual turnover	Date of registration	Role in the business
		R	(dd/mm/yyyy)	
		R	(dd/mm/yyyy)	
		R	(dd/mm/yyyy)	
		R	(dd/mm/yyyy)	

8. Banking details

Please provide us with proof of the banking details for the account holder from the bank as well as the following information:

Name of account holder					
Account number				Name of bank	
Type of account	Savings		Current	Branch code	

9. Consent for Disclosure of Confidential Information and Declaration

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

with ID number _____ hereby voluntarily grant authorisation to medical practitioners to disclose my medical and personal records to the medical practitioners appointed by Sanlam to assess (and review) my disability. This includes my previous medical history as well as any psychological or psychiatric records for the purposes of determining my ability to perform work.

I also declare that I have no objections to my medical information being supplied to and obtained from, either directly or through a data base operated by or for insurers as a group, Sanlam's medical advisor, the employer, fund, ombudsman, legal representatives, other insurers, reinsurers and/or the medical service providers involved in the disability assessment and rehabilitation processes if necessary, for the purposes of underwriting risks or assessment and review of any claim for benefits under a policy.

I also irrevocably authorise any medical practitioner, medical specialist, health professional, hospital, medical scheme, or any other person or institution 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 accept and understand that I am limiting my right to privacy to the extent permitted by me in this authorisation, to facilitate the validation and assessment (and review) of my disability claim under the group insurance policy, or any other reason including detection and prevention of fraudulent claims. I acknowledge that I cannot cancel this authorisation and that it will endure even after my death.

I will not hold Sanlam and/or its directors, agents, intermediaries and/or employees liable for any consequences that may arise as a result of such sharing/disclosure and/or collection of my personal information.

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		Date	
Signature of employee		Signature of witness	
		Full name(s) and surname of witness	

Disclaimer: Party Due Diligence requirements

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.

Protection of Personal Information Disclosure

Why Personal Information is required: Sanlam Life Insurance Limited ("Sanlam Life"), a subsidiary of Sanlam Limited, will process and protect your personal information as required by relevant laws and the Constitution of the Republic of South Africa ("RSA"). The personal information requested in this form, which may include special personal information is being collected and will be processed for the following purposes:

- underwriting and providing accurate and effective insurance cover and related value-added services;
- member communication;
- market research and statistical analysis;
- verification of the personal information provided;
- to comply with all legal and regulatory requirements, including applicable codes of conduct;
- for operational and administrative processes;
- to protect Sanlam Life's interests; and
- any purposes related to the above;
- Claims checks (Industry Life and Claims Register(s))

Failure to provide the mandatory information will prejudice your insurance cover.

Changing and correcting Personal Information: You have the right to:

- Request a copy of your personal information as processed by Sanlam Life;
- Ask for an update and/or correction of your personal information;
- Lodge a complaint with the Information Regulator.

Sanlam Life may charge an administrative fee subject to prior notice of any such cost before executing the request for a copy of your personal information.

Other parties that may receive the Personal Information:

- We may share your personal information within Sanlam Limited and/or with other service providers where required for any of the purposes listed above, or with third parties where Sanlam Life is lawfully required to do so.
- We may send your personal information to service providers outside the RSA for storage or further processing on Sanlam Life's behalf. We will not send your information to a country that does not have information protection legislation similar to that of the RSA, unless we have a binding agreement with the service provider which ensures that it effectively adheres to the principles for processing of personal information in accordance with the Protection of Personal Information Act, 2013.

For more information, please refer to the Sanlam Group Privacy Notice.

Guidelines for confidential medical report

Important: The examination and compiling of a medical report must be done by the patient's treating specialist. Only if there is no treating specialist attending to the insured, may a general practitioner complete the report.

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.

Please complete the attached Confidential Medical Report form. If you choose to submit a typed report, then the guidelines below apply.

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 tests / 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/V for psychiatric conditions)
- Date of onset and course of disease
- Severity, perpetual factors, secondary gain
- Current clinical findings. Please provide a detailed description.
- Treatment:
  - Treatment modalities
  - Types of medication and dosage
  - Duration of treatment
  - Therapeutic procedures
  - Rehabilitation
  - Hospitalisation
  - Assistive Devices / technology
  - Date of consultations
- Response to treatment and side effects
- Compliance with treatment
- Complications that are permanent
- Special investigations (e.g. ECG, X-rays, scans, blood tests, laboratory test results, etc.)
- 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, echocardiogram, 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 (e.g. nerve conduction tests).
  - Neurological: MRI, CAT scan results, EKC other.
  - Surgery: Surgical report.
  - Psychiatric: social functioning, concentration, psychometric tests in cases of cognitive impairment, frequency and dates of consultations.
  - Immunocompromised conditions: blood tests, CD4 count and viral load.

Confidential Medical report: Disability

Dear Doctor,

Thank you for your time.

We request your assistance with getting a better understanding of the claimant's medical condition to support their claim for disability benefits. Your thorough completion of this document will help to expedite our assessment process.

Please note that the cost for completion of this report is for the policyholder's account.

Kindly return the completed report with copies of all relevant clinical or diagnostic tests results or any additional medical information you have available, to sgrdisabilityclaims@sanlam.co.za

Scheme and Insured's details		
Name of fund / scheme		
Name of employer		
Full name of insured		
Insured's identity number*		**Compulsory*
Insured's date of birth		*(dd/mm/yyyy)*
Membership number		

Medical practitioner information			
Full names and surname			
Postal address			
		Postal code	
E-mail address			
Telephone number			
Qualification			
Practice number			

SECTION A: Course of illness		
Since when has the claimant been your patient?		*(dd/mm/yyyy)*
Most recent examination date:		*(dd/mm/yyyy)*

Previous consultations:

Date *(dd/mm/yyyy)*	**Diagnosis**	**Treatment**

When was the first diagnosis made?		*(dd/mm/yyyy)*
When did the symptoms present for the first time?		*(dd/mm/yyyy)*

Current complaints from the claimant's point of view:

After consultation, what symptoms does the claimant currently present with? (list all):

What permanent complications of the condition have you identified?

Specialist consultations and special investigations done:

Consultations or investigations done	**Date** *(dd/mm/yyyy)*	**Results**

Very Important: If you have any specialist reports / psychiatric reports / special investigations (e.g. X-rays, scans, ECG's, lung-function tests, histology reports), please supply copies.

Current medical examination:

Weight		Height		BP	
Pulse		Cholesterol		Blood glucose	

SECTION B: Treatment

Current medication:

Name / Type	Dosage	Duration

Previous medication:

Name / Type	Dosage	Duration

Other forms of treatment (e.g. physiotherapy, rehabilitation, surgery, ECG or psychotherapy)

Type	Name of Doctor / Therapist	Contact details	Period of treatment

Please comment on the claimant's compliance to treatment/medication:

Do you consider this treatment optimal? If not, please elaborate:

SECTION C: Prognosis					
Please give your opinion on the prognosis:					
Since when has the claimant been unable to perform the tasks of their regular occupation due to their condition?					
Will further treatment, rehabilitation or work modification lead to improvement of the claimant's ability to function? Please elaborate.					
When, in your view, will the insured be able to resume their employment or any part thereof?					
Full time		*(dd/mm/yyyy)*	Part-time		*(dd/mm/yyyy)*

SECTION D: Functional impairment

In order to determine the claimant's functional ability to pursue a specific occupation, would you please indicate to what extent they can carry out the activities listed in the table below. If possible, these abilities should be weighed relatively as it would have been if they did not have the injury/illness. The claimant's age, intelligence or natural capabilities should not be considered.

Activity / Task / Function	**Please describe the claimant's ability to carry out the task e.g.** *Impossible, possible with much/little pain/discomfort, dangerous to themselves/others, no limitations, etc.*	**Will this capability most likely:** *improve, worsen or remain constant?*	**If possible, please estimate the period over which change will occur.** *(weeks/months/years)*
Clerical or administrative work (sedentary occupation)			
Concentration			
Memory			
Interaction with others (colleagues, clients, etc.)			
Supervisory work			
Sit continuously for more than an hour			
Sit continuously for less than an hour			
Stand continuously for more than an hour			
Stand continuously for less than an hour			
Walks (minimal effort) on level ground			
Walks (with effort) on uneven ground			
Bend, crouch, kneel, crawl, balance			
Climb steps/ladder			
Handling of heavy objects (more than 10kg)			
Handling of light objects (less than 5kg)			
Handling of heavy machinery			
Handling of light machinery			
Fine manual work (e.g. writing, typing, small electrical repairs)			
Driving of heavy vehicle			
Driving of light vehicle			

SECTION E: Additional questions
Claimant’s co-operation/motivation (e.g. with regards to medication, smoking, weight loss):
Other factors that might influence the insured's ability to work (e.g. alcohol, drug dependence, motivation, social problems, conflict with colleagues at present workplace):
Please provide any other information that may assist Sanlam in assessment of this claim:

Signature of medical practitioner		Date	
		Place	
Please provide practice stamp:			