Claim for Lump sum Disability Benefit and/or Monthly Disability Income Benefit

Confidential

1 Contents

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

- Declaration by fund/scheme
- Particulars **of the insured's occupation.**
- Payment **of benefits.**
- Declaration **by insured.**
- Confidential **medical report:**
  Report to be compiled by insured's treating specialist according to the guidelines attached. (See page 11).
- **Sick leave records:**
  Provide copies of all sick leave records for the past 12 (twelve) 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 (three) year's salary statements.
- Identity **document:**
  Please provide a copy of the insured's identity document.

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 Absa may reasonably require.

The employer must please either post, fax or email the duly completed forms to:

Absa Group Schemes
3rd Floor
Towers North
180 Commissioner Street
Johannesburg, 2001
Email: sufsclaims@absa.co.za

Absa Life Limited Reg No 1992/001738/06
Authorised Financial Services Provider

Absa 6764 EX (05/02/2019)

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

A **Particulars of fund/scheme**

Name of fund/scheme

Scheme code | Name of branch/participating employer

Email address

Telephone number | Contact person

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-habit Widowed

Identity number

Particulars of membership

Membership number | Pay-sheet number (if any)

Date of entering service (dd/mm/ccyy) | Date of permanent appointment

Date of commencement of membership (dd/mm/ccyy)

If the scheme has been underwritten by Absa Life for less than 1 (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 received cover at the previous insurer? (dd/mm/ccyy)

Salary information for the past 3 (three) 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 Absa Life, 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**	**Amount of *medical aid premium**
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 Absa Life 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 superviser	
Telephone number	
Name of contact person at Human Resources department	
Telephone number	
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	
Superviser	
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					

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? (dd/mm/ccyy) Until which date? (dd/mm/ccyy)

Education qualification of insured

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?

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)

Payment of benefits

Important:

The person who completes this part of the form, must familiarise themselves with the disability benefits the insured is/are covered for in terms of the policy agreement. Should the claim for the disability benefits become payable (after applying the waiting period and other policy payment stipulations) Absa will rely on the information provided in the applicable sections of the form.

Submitting incorrect or insufficient information can lead to incorrect and/or delayed payment of the disability benefit(s).

The information supplied will only be used once the claim has been admitted.

Mark the applicable option with an "X".

While the insured is absent from the workplace, will the insured still receive a monthly salary? Yes | No

In answered "**Yes**", until when will the insured receive a monthly salary? (dd/mm/ccyy)

In answered "**No**", until when will the insured receive a monthly salary? (dd/mm/ccyy)

Please confirm the insured's last date of performing his/her duties? (dd/mm/ccyy)

Note: Only complete the payment instruction sections based on the applicable disability benefits the insured is/are covered for in terms of the policy agreement.

Lump sum disability benefits payable to the fund in terms of the policy agreement:

Please provide the banking details of the fund.

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Lump sum disability benefits payable to the insured in terms of the policy agreement:

Please provide the banking details of the insured.

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Salary refund disability benefits payable to the employer in terms of the policy agreement:

Please provide the banking details of the employer.

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Spouse or Accident benefits payable to the spouse/insured in terms of the policy agreement:

Please provide the banking details of the spouse/insured.

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Note: The policy agreement provides for Income Continuation disability benefit, Income Care disability benefit, Top Up disability benefit and the Medical Aid Premium Waiver benefit. It is possible that an insured may be covered for more than one of the benefits.

Please complete the applicable sections and provide the necessary banking details.

Income Continuation disability benefit/Income Care disability benefit payable to the employer in terms of the policy agreement:

Please provide the banking details of the spouse/insured.

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Email address where payment advice must be sent to

Name and surname | Telephone number

Income Continuation disability benefit/Income Care disability benefit payable to the insured in terms of the policy agreement:

Please provide the banking details of the spouse/insured.

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Note: If the policy agreement makes provision for the payment of employer (company) contributions, please complete this sections and provide the banking details of the fund - if payable to the fund, or the employer's - if payable to the employer.

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Email address where payment advice must be sent to

Name and surname | Telephone number

Note: If the insured, before he/she became disabled, paid member contributions to the fund, Absa Life can continue deducting the contributions from the insured's monthly disability benefit and pay it to the fund. Deducting such contributions is however not in terms of the policy agreement and therefore the insured's prior consent is required.

Please provide the member contributions percentage, to be deducted from the insured's monthly disability benefit and the banking details of the fund.

Member contribution percentage ( )%

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Email address where payment advice must be sent to

Name and surname | Telephone number

Top Up benefit payable to the employer in terms of the policy agreement:

Please provide the banking details of the employer.

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Email address where payment advice must be sent to

Name and surname | Telephone number

Top Up disability benefit payable to the insured in terms of the policy agreement:

Please provide the banking details of the insured.

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Medical Aid Premium Waiver benefit payable to the employer in terms of the policy agreement:

Please provide the banking details of the employer.

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Email address where payment advice must be sent to

Name and surname | Telephone number

Medical Aid Premium Waiver benefit payable to the medical aid scheme:

Please provide the banking details of the medical aid scheme.

Name of member's medical aid scheme

Medical aid membership number

Name of accountholder

Name of bank | Name of branch

Account number | 6-digit branch code

Type of account: Current ☐ Savings ☐ Transmission ☐

Email address where payment advice must be sent to

Name and surname | Telephone number

Important:

In terms of the policy agreement, premiums in respect of the insured's benefits is/are still payable.

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 | Initials and surname

Designation | Designation

Signature _____ | Signature _____

Place | Date (dd/mm/ccyy)

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

Name of insured

Date of birth (dd/mm/ccyy) | Identity number

Telephone number | Cell

Email address

Postal address

Postal code

Residential address

Postal code

1 **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

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

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)

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	Date of cession

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

Tax particulars

Income tax reference number

Income tax office to which last return was rendered

4 **Declaration**

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

Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks and the consideration of any claim for benefits under a policy related to this or any other proposal for insurance made by me, or in respect of me as insured, I irrevocably authorise Absa Life to:

- Obtain from any person whom I hereby so authorise and request to give any information which Absa deems necessary.
- Share with other insurers that information contained in this proposal or in any related policy or other 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 Absa Life or by the operators of such data base.

Signature of insured _____

Name and surname of insured	
Witness	
Date (dd/mm/ccyy)	
Place	

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,

Absa 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 Absa Life Insurance Limited.)

Kindly supply Absa Life 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.

*In receiving your report you will guarantee us that the information that you will provide is true and accurate to the best of your knowledge and can be relied on.

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/V 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 V02 max.) vitalogram pre-and post-inhalation (3 attempts), chest X-ray, single-breath diffusion test (Dco) in cases of interstitial lung disease.
  - 0rthopaedic: X-ray and stress views, MRI or CAT scans, other (e.g. nerve conduction tests).
  - Psychiatric: social functioning, concentration, psychometric tests in cases of cognitive impairment.