



Claim for Disability/Income Protector/ Overhead Expenses Claim

Please return the completed form to: **Policy claims**

Postal address PO Box 1, Sanlamhof 7532
E-mail address claimbenefits@sanlam.co.za

Telephone number (021) 916-3455
Fax number (021) 947-5804

Important

- An accurately completed form is essential in order to avoid delays in the assessment process. A claim can be considered only if all required documents and all the supplementary statements (as indicated below) have been completed in full and are in Sanlam Life's possession.
- It is also important that you should be aware of the implications of the non-payment /payment of this claim for your financial position. We therefore strongly recommend that at this stage you should already contact your financial advisor to assist you in this regard.
- This form and all relevant documents can be sent to us by e-mail, fax or per post. If readable copies of documents are provided to us, the original documents are unnecessary.

Please supply the following documents:

- The *Declaration by Employer*- form (if you are not self-employed).
- The attached Declaration by attending doctor form for an Income Protector / Overhead Expenses Protector claim form (form number CPC003E).
- A copy of the hospital account, if you were hospitalised.
- If self-employed or if your claim is against the Overhead Expenses Protector benefit, please complete the Overhead expenses questionnaire.
- If you are self-employed, please provide us with proof of the existence of your business, e.g. audited financial statements or tax assessments and returns, receipts or affidavits from persons with whom business have been done.
- A copy of your identity document.
- Copies of all medical certificates which indicate your sick leave period(s) as well as those by which you were medically boarded.
- A report by the treating specialist (attached).
- SAPS report/Reports of injury sustained at work if a claim was caused by an accident, as well as the result of the investigation if already finalised.

Note: You can only claim for the illnesses listed in your own contract.

If abroad, provide all medical documentation in English.

Particulars of insured life

Plan number(s) _____

Surname _____

Full first names _____

Date of birth ____/____/____ (dd/mm/ccyy)

Identity number _____ (Compulsory) Land of issue _____

Pass port number _____ Expiry date ____/____/____ (dd/mm/ccyy)

Title: Mr Mrs Miss Ms Rev Dr. Prof. Adv. Judge

Gender Male Female

Postal address _____ Postal code _____

Residential address _____ Postal code _____

Contact details: Telephone (home) (____) _____ Fax (home) (____) _____

Telephone (work) (____) _____ Fax (work) (____) _____

Cell phone _____

E-mail address _____

Marital Status: Single Married Divorced Co-habiting Widowed

Race White Asian Coloured Black Unknown (For statistical purposes)

Income office _____

Income tax number _____

Plan number _____

Nature of claim (functional impairment)

- What illness, injury of disorder gave rise to your claim?

- On which date did you consult a doctor regarding these symptoms? _____ / _____ / _____ (dd/mm/ccyy)
- State the initials, surname, address and telephone number of this doctor.

- Describe the symptoms which you are experiencing and state the date the symptoms began:

- Give a brief description of how the symptoms you mentioned have limited your ability to work:

- How do you spend your time? _____
- Were you hospitalised? Yes No
If "Yes" please give the name of the hospital _____
(A copy of the hospital account is required with admission and discharge dates and times)
Admission date _____ / _____ / _____ (dd/mm/ccyy) Discharge date _____ / _____ / _____ (dd/mm/ccyy)
Time of admission _____ Time of discharge _____
- Describe in what respect you have in any way been impeded in attending to your personal interest or in carrying out the everyday care of your person:

Medical history

- State the initials, surname, address and telephone number of your
 - Present family doctor _____
Telephone number (_____) Fax number (_____)
 - Previous family doctor _____
Telephone number (_____) Fax number (_____)
- Since which date have you been consulting your present family doctor? _____ / _____ / _____ (dd/mm/ccyy)
- Provide the following information with regard to all other doctors/specialists you have consulted regarding the condition that caused the claim.

Details for hospitalisation for special investigations or treatments

Name of hospital	Reason for hospitalisation	Patient number	Admission dd / mm / ccyy	Discharge dd / mm / ccyy
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

Plan number _____

Medical history *(continue)***Details of doctors, specialists and consultations**

Name and surname	Type of specialist	Address	Telephone number	First consultation dd / mm / cyy
			()	/ /
			()	/ /
			()	/ /

Public health sector

Name and surname	Type of specialist	Address	Telephone number	First consultation dd / mm / cyy
			()	/ /
			()	/ /
			()	/ /
			()	/ /

• Medical Aid details:

- Name of the fund _____
- Membership number _____

Other information

- If the illness or injury occurred in a country outside South Africa, please provide the following:

Country visited _____

Reason for visit _____

Date of arrival ____ / ____ / ____ (dd/mm/ccyy) Date of return ____ / ____ / ____ (dd/mm/ccyy)

Accident particulars

- Date of accident ____ / ____ / ____ (dd/mm/ccyy)
- Place of accident _____
- The disability was caused by Motor vehicle accident Accident at home Accident at work
 Shooting accident Other (specify) _____

- Give a brief description of how the accident happened:

- If there was an investigation into the cause of the accident, provide the following:

Name of police station _____

Case number _____

Initials and surname of investigating officer _____

Contact details Telephone number () Fax number ()

Findings of the investigation (provide copy of the SAPS report/Report of injury sustained at work/Court report):

Plan number _____

Accident particulars *(continue)*

- Did you suffer any physical loss? Yes No

If "Yes", describe the nature of the loss you suffered

If the loss did not happen on the date of the accident, please state the date _____ / _____ / _____ (dd/mm/ccyy)

Occupational history

- Provide a detailed statement of your career, including your present or last occupation. The exact dates (at least month and year) of the commencement and termination of your service are required.

Name of employer	Address	Telephone number	Commencement dd / mm / ccyy	Termination date dd / mm / ccyy	Nature of work
		()	/ /	/ /	
		()	/ /	/ /	
		()	/ /	/ /	
		()	/ /	/ /	

- What was the last date on which you were actively able to do your work? _____ / _____ / _____ (dd/mm/ccyy)
(Not necessarily the date of termination of service.)

- Date of official discharge _____ / _____ / _____ (dd/mm/ccyy)

- Describe the most important functions of your occupation(s) from which you earned an income immediately before your disability. *(from the date of official discharge)*

- State the percentage of time engaged in the actions below as well as the nature of it.

Administrative duties _____ % _____
 Manual / physical duties _____ % _____
 Supervisory duties _____ % _____
 Travelling by car, truck, etc. _____ % _____
 Walking and standing _____ % _____
 TOTAL _____ 100 % *(Note: The percentages must add up to 100%.)*

- What is your highest educational qualification? *(e.g. St.10/Gr. 12 or B.Com)* _____
- At which school or institution did you qualify? _____
- Any other qualifications obtained? _____
- Any skills and/or courses acquired or passed while in service? _____
- Any study area / business qualifications? _____
- If you are doing any work at present, from which you are earning an income, state the type of work and the income earned:

Provide the name, address, telephone and fax numbers of the relevant employer:

Telephone number () _____ Fax number () _____

- If you are not working at present, do you intend to do so in the future? Yes No

- If "Yes", what type of occupation do you have in mind and from which date? From (dd/mm/ccyy)

- If "No", in your opinion, what prevents you from performing full-time employment?

Plan number _____

Income particulars

- What was your gross monthly income during the last 12 months before the onset of your disability? (Please indicate any overtime payment separately.)

Gross R _____ Overtime R _____

- Provide the following information if, owing to or during your disability you are receiving, or are entitled to receive any benefit, salary, pension or remuneration of any kind (this includes money received from any employer, partner, assurance company, pension or retirement annuity fund, any government fund or from any other source – irrespective of whether a claim has been submitted):

Source of benefit / name of company	Amount (R)	Frequency of payment	Inception date dd / mm / cyy	Cessation date dd / mm / cyy
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

- What were your sources of income immediately before disability? Please tick the relevant boxes and mention the monthly income amounts.

Salary from employer R _____ Self-employed R _____

Rental income R _____ Pension R _____

Investment income R _____ Other R _____

Specify other: _____

Important

Fill in this section only if you were self-employed. Please provide us with proof of existence of your business.

- What were your operating costs for the 12 months prior to disability?

- What will happen to your business now that you are disabled?

- If you are continuing with your business, what is your Involvement (e.g. how are you involved in running the business and what is your share of the profit)?

- What duties did you do before your disability?

- What duties do you still do after your disability?

- Have you had to appoint people to continue running your business? Yes No
- If "Yes", at what cost has this been done? (Please attach documentary evidence such as salary statements.)

Plan number _____

Payments

Please note that the payments must be continued until a claim, if any, has been admitted.

Bank particulars

Provide us with a copy of your bank statement (not older than three months) on a bank letterhead containing the account number and account holder's name.

Please complete **one** of the 3 options provided

1. Payment to the owner of the plan(s).

If the claim of the life insured is admitted, Sanlam Life can make the money available by means of an electronic bank transfer to the owner of the plan. Please provide us with the following details:

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Account holder _____

Type of account Cheque Savings Transmission Other _____ (Specify)

I, the undersigned, hereby declare that if the above information is not correct, Sanlam Life cannot be held liable for any loss that may arise from the use of this information.

Signature of account holder _____

Date ____ / ____ / ____ (dd/mm/ccyy)

2. Payment to cessionary

Important

If any plan, in terms of which a claim is admitted, has been ceded to another institution or person, payment will be made directly to the cessionary in question. The next section must be completed by the cessionary if applicable.

Complete if any of your policies are ceded:

Relevant plan number(s) _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Account holder _____

Type of account Cheque Savings Transmission Other _____ (Specify)

Or

I hereby give permission for the cession to be cancelled: _____

Name of contact person _____ Contact number: (____) _____

Signature of cessionary _____ Official stamp of institution
Signature of cessionary _____

Date ____ / ____ / ____ (dd/mm/ccyy)

Plan number _____

Bank particulars *(continue)***3. Proxy and/or payment to a third party**

If the plan owner would prefer the claim/payment to be handled/received by another person/institution, please provide us with the details below:

I, (plan owner) first names and surname: _____

Hereby authorise the person indicated below to handle the claim/receive the payment on my behalf and I indemnify Sanlam Life against any and all claims in respect of, and in connection with, the payment by Sanlam of the amount(s) concerned to this third party. (delete where not applicable)

Initials and surname of the person that _____
could handle the claim on my behalf:

Address _____ Postal code _____

Initials and surname of the person that _____
could receive the payment on my behalf:

Identity number _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Account holder _____

Type of account Cheque Savings Transmission Other _____ *(Specify)*

Signature of plan owner _____

Date ____ / ____ / ____ *(dd/mm/ccyy)*

Declaration

I declare that the particulars contained in this form are correct. I also irrevocably authorise any person or institution, medical practitioner, medical specialist, hospital, nursing institution or medical authority to provide Sanlam Life with any information that may be required regarding my health.

Further, I irrevocably authorise Sanlam Life to share with other insurers that information and any information contained in this proposal or any related plan 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 Sanlam Life or by the operators of such data base.

Signature of insured/claimant _____

Date ____ / ____ / ____ *(dd/mm/ccyy)*

The Treating Specialist*Important*

This report must be completed by a specialist and not a general practitioner

Before you perform the examination, please determine the client's identity with the help of a photographic proof of identity. Indicate on the report of your findings – what type of proof of identity was given.

The above-mentioned insured has required us to consider whether he/she qualifies for a disability claim.

The assessment of a disability claim is based on two main principals of impairment and disability. The assessment of impairment entails in practical terms, making a diagnosis and then determining on medical grounds which functions the person is still able to perform and which not. On the other hand, disability is a legal process assessing the extent of the person's impairment judged in conjunction with his/her job description the contract wording and personal factors such as education, experience, etc.

To assist us in making a justified decision, we have to be provided with a report regarding the impairment of this person. The decision regarding disability will be made by Sanlam Life Insurance Ltd ("Sanlam Life").

Please complete the report in accordance with the guidelines set out in the "Guidelines: Medical report on functional impairment" underneath after you have examined the person.

The insured is responsible for the costs relating to this consultation and medical report.

Plan number _____

Guidelines : Medical Report on Functional Impairment

Please use the following only as a guideline to compile your report.

- Diagnosis: (DSM IV for psychiatric conditions)
- Date: Of the onset and course of disease
- Severity: Perpetual factors, secondary gain
- Current clinical findings: Describe in detail
- Treatment:
 - Treatment modalities
 - Duration of treatment
 - Rehabilitation
 - Types of medication and dosage
 - Therapeutic procedures
 - Hospitalisation
- Response to treatment
- Complications that is 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 VO ₂ 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)
Psychiatric	Social functioning, concentration, psychometric tests in cases of cognitive impairment.