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Sanlam Risk Benefits

2736E

Declaration by Employer
Claim for Disability

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

Postal address	PO Box 1, Sanlamhof 7532	Telephone number	(021) 916-3455
E-mail address	claimbenefits@sanlam.co.za	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.

Please supply the following documents:

- Sick leave certificates - see page 3.
- Copy of Discharge certificate
- Non-generic job description.

Particulars of insured life

Plan number(s) _____ _____ _____

_____ _____ _____

Surname _____

Full first names _____

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

Identity number _____ *(Compulsory)*

Residential address _____ Postal code _____

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

Cell phone _____

E-mail address _____

Particulars of Employer

Full names and surname / Name of institution _____

Name of Group Scheme *(only if applicable)* _____

Employee reference number of claimant _____

Postal address _____ Postal code _____

Name of contact person _____

Contact numbers: Telephone (____) _____ Fax (____) _____

E-mail address _____

Plan number _____

General information

- Date of appointment ____/____/____ *(dd/mm/ccyy)*
- Name of occupation _____
- Date of appointment in this occupation ____/____/____ *(dd/mm/ccyy)*
- Define the essential functions of this occupation: **Please attach a non-generic job description.**

_____

_____

- Last date on which claimant was still actively able to perform his/her job. ____/____/____ *(dd/mm/ccyy)*
- Date of official discharge. ____/____/____ *(dd/mm/ccyy)*
- State the percentage of time the claimant engaged in the actions below. *(Note: the percentage must add up to 100%.)* Please indicate the specific actions performed per percentage.

Administrative duties	____	%	_____
Manual / physical duties	____	%	_____
Supervisory duties	____	%	_____
Travelling by car, truck, etc.	____	%	_____
Walking and standing	____	%	_____
Total	100	%	

- Please state the academic qualifications of the claimant. _____
- Gross average monthly salary before disability Basic R _____
  Overtime R _____
  Other R _____
- Gross average monthly salary after disability Basic R _____
- Gross monthly pension after disability R _____

Description of employee's disability (functional impairment)

- What is the cause of his/her disability?

_____

_____

- When did you first become aware of the condition? ____/____/____ *(dd/mm/ccyy)*
- Was the cause an injury sustained while on duty? Yes ☐ No ☐

  If "Yes", please provide us with the *Injury sustained at work* - report.
- Current work status *(Please mark the applicable option)*

  Still at work ☐
  Working part-time ☐
  On sick-leave ☐
  Early retirement due to ill health ☐
  Working in alternative position ☐ If this option is selected, please answer the following questions:
  - If the person was not considered for an alternative position , was it as a result of:
    - Lack of knowledge and/or experience? Yes ☐ No ☐
    - Unable to engage emotional or physical? Yes ☐ No ☐
  - If the person accepted an alternative position, please answer the following questions:
    - Did the aspects mentioned below contribute to his/her appointment to the alternative position? Please provide reasons.

      Training Yes ☐ No ☐ _____
      Experience Yes ☐ No ☐ _____
      Education Yes ☐ No ☐ _____

Plan number _____

Description of employee's disability (functional impairment)

Alternative position (continue)

- Describe in full what his/her duties in the alternative position comprise and indicate exactly the nature of what he/she now does. (For example, it is not sufficient to say "He/she performs light clerical work" – please indicate the nature of the clerical work):

_____

_____

_____

- Percentage time spent engaged in: *(Note: the percentage must add up to 100%.)* Please indicate the specific actions performed per percentage.

Administrative duties	_____ %	_____
Manual / physical duties	_____ %	_____
Supervisory duties	_____ %	_____
Travelling by car, truck, etc.	_____ %	_____
Walking and standing	_____ %	_____
Total	100 %	

- Educational qualifications required for the alternative position:

_____

- Gross earnings in the alternative position Basic R _____
  Overtime R _____
  Other R _____
- Has he/she been appointed on a part-time or permanent basis? Part-time ☐ Permanent ☐
- Does the employee have any promotion opportunities? Yes ☐ No ☐
- Is the status of the alternative position higher than, equal to or lower than the position previously held?

_____

- Please provide the reasons if an alternative position was offered, but the claimant did not accept the position.

_____

_____

_____

_____

Sick leave records

- Please provide us with a brief summary of all sick leave of longer than 2 days taken by the claimant during the past two years. Please include copies of the relevant doctor's certificates.

Illness or injury	**Name of doctor(s) consulted**	**Dates from work**		**Total days absent**
		From *(dd/mm/ccyy)*	**To** *(dd/mm/ccyy)*	

Plan number _____

Sick leave records *(continue)*

- Contact person with regard to sick leave records: _____

  Contact number: Telephone ( ) _____ Fax ( ) _____

  E-Mail address _____

Declaration by Employer

I hereby declare that the information provided within is correct and no information was withheld.

Signature of authorised official _____

Name of authorised official _____

Capacity of authorised official _____

Date / / *(dd/mm/ccyy)* Place _____

Official stamp of institution _____