



## Declaration by Employer Claim for Disability

Please return the completed form to: **Living Benefit Claims**

Postal address PO Box 1, Sanlamhof 7532 Telephone number (021) 916-3455  
E-mail address livingbenefits@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	<input type="checkbox"/>	No	<input type="checkbox"/>	_____
Experience	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	_____
Education	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	_____

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 \_\_\_\_\_