Claim for Disability / Income Protector / Overhead Expenses Claim

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

- Our client experience has proven that generally claims are handled more efficiently when clients make use of his/her financial adviser. It also helps with the financial planning that is now so crucial due to your circumstances that have probably changed. Therefore please make use of your financial adviser. His /Her detail is provided in your policy contract and/or annual reports. 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:

- Copies of all medical reports/certificates which indicate your sick leave period(s), as well as more recent or not older than 6 months, report from your treating specialist(s) (guidelines attached).
- The *Declaration by Employer*-form (if you are not self-employed).
- The attached Declaration by attending doctor form, to be used only for disability claims.
- Please also use the Declaration by attending doctor-form (CPC003, available on the Sanlam website) for an Income Protector / Overhead Expenses Protector claim.
- A copy of the hospital account, if you were hospitalised.
- If self-employed or if your claim is for the Overhead Expenses Protector benefit, please complete the Overhead expenses questionnaire. Available on request.
- 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.
- 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 ______________

Passport 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 ______________

Licensed Financial Services and Registered Credit Provider (NCRCP43)

Plan number(s) ______________________________

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? ______________________________

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)*
- Medical Aid details:
  - Name of the fund ______________________________
  - Membership number ______________________________
- 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/clinic	Reason for hospitalisation	Patient number	Admission *(dd/mm/ccyy)*	Discharge *(dd/mm/ccyy)*
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

Details of doctors, specialists and consultations

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

Plan number(s) ______________________

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 and the loss which occurred

  ____

  ____

  ____

- 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 (   ) ______________

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.

  ____

- 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%.)*

Licensed Financial Services and Registered Credit Provider (NCRCP43)

Plan number(s) ______________________________

Occupational history *(continued)*

- 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)*

  ____

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 of 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/ccyy)*	**Cessation date** *(dd/mm/ccyy)*
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

- 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: ______________________________

  ____

  ____

Plan number(s) ______________________________

Income particulars *(continued)*

Self-Employment

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.)*

  ____

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.

(*In accordance with section 37A of the Pension Funds Act, the benefit that a member is entitled to may be paid out only to that member, therefore only option 1 applies for claims on Annuity/Preservation fund policies.*)

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1. Details of account holder/plan holder

A. Natural person / legal entity

Title ______________

Full names and surname /Registered name of legal entity ______________________________

Previous / Maiden name ______________________________

National identity number ______________________________

Issueing country of identity number ______________________________

Nationality/Citizenship ______________________________

Gender Male ☐ Female ☐ Date of birth ____/____/________ *(dd/mm/ccyy)*

Country of residence ______________________________

Country of birth ______________________________

Monthly income R ______________ Date of last income ____/____/________ *(dd/mm/ccyy)*

Plan number(s) ______________________________

Details of account holder/plan holder *(continued)*

Residential Address ______________________________

____

______________________________ Postal/Zip code __________

Trade name of legal entity ______________________________

Legal entity type:

Listed company ☐ Unlisted company ☐ Close corporation ☐ Trust ☐ Deceased estate ☐ Partnership ☐ Other legal person ☐ Retirement Fund ☐

Non-growth organisation ☐ Non-profit organisation ☐ Charitable organisation ☐ Foundation ☐ State owned enterprises ☐ Joint ownership ☐

Registration number ______________________ Country of registration ______________

Registered address ______________________________

____

______________________________ Postal/Zip code __________

Controlling party/Beneficial owner ______________________________

B. Bank details

Account holder ______________________________

Name of bank ______________________ Name of branch ______________

Account number ______________________ Branch code ______________

Type of account: Current ☐ Savings ☐ Transmission ☐ Other *(please 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.

A. Natural person / legal entity

Title ______________

Full names and surname /Registered name of legal entity ______________________________

Previous / Maiden name ______________________________

National identity number ______________________________

Issueing country of identity number ______________________________

Nationality/Citizenship ______________________________

Gender Male ☐ Female ☐ Date of birth ____/____/________ *(dd/mm/ccyy)*

Country of residence ______________________________

Country of birth ______________________________

Monthly income R ______________ Date of last income ____/____/________ *(dd/mm/ccyy)*

Plan number(s) ______

Payment to cessionary *(continued)*

Residential Address ______

______

______ Postal/Zip code ______

Trade name of legal entity ______

Legal entity type:

Listed company ☐ Unlisted company ☐ Close corporation ☐ Trust ☐ Deceased estate ☐ Partnership ☐ Other legal person ☐ Retirement Fund ☐

Non-growth organisation ☐ Non-profit organisation ☐ Charitable organisation ☐ Foundation ☐ State owned enterprises ☐ Joint ownership ☐

Registration number ______ Country of registration ______

Registered address ______

______

______ Postal/Zip code ______

Controlling party/Beneficial owner ______

B. Bank details

Account holder ______

Name of bank ______ Name of branch ______

Account number ______ Branch code ______

Type of account: Current ☐ Savings ☐ Transmission ☐ Other *(please 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.

Or

I hereby give permission for the cession to be cancelled.

Name of contact person ______ Contact number ( ) ______

Signature of cessionary ______ Official stamp of institution ______

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

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, ______ *(first names and surname of the plan holder),*

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/Zip code ______

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

Plan number(s) ____________________

Proxy and/or payment to a third party *(continued)*

Title ____________

Full names and surname /Registered name of legal entity ____________________

Previous / Maiden name ____________________

National identity number ____________________

Issueing country of identity number ____________________

Nationality/Citizenship ____________________

Gender Male ☐ Female ☐ Date of birth ___/___/______ *(dd/mm/ccyy)*

Country of residence ____________________

Country of birth ____________________

Monthly income R ____________ Date of last income ___/___/______ *(dd/mm/ccyy)*

Residential Address ____________________

____

____________________ Postal/Zip code ________

Trade name of legal entity ____________________

Legal entity type:

Listed company ☐ Unlisted company ☐ Close corporation ☐ Trust ☐ Deceased estate ☐ Partnership ☐ Other legal person ☐ Retirement Fund ☐

Non-growth organisation ☐ Non-profit organisation ☐ Charitable organisation ☐ Foundation ☐ State owned enterprises ☐ Joint ownership ☐

Registration number ____________ Country of registration ____________

Registered address ____________________

____

____________________ Postal/Zip code ________

Controlling party/Beneficial owner ____________________

Source of funds ____________________

B. Bank details

Account holder ____________________

Name of bank ____________ Name of branch ____________

Account number ____________ Branch code ____________

Type of account: Current ☐ Savings ☐ Transmission ☐ Other *(please 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 plan owner ____________________ Date *(dd/mm/ccyy)* ____________

Plan number(s) ______________________________

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 or any other stakeholders for the purposes of assessing, investigating, processing or any other reason including prevention of fraudulent claims that information and any information contained in this plan 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 *(only for a disability claim)*

Important
This report must be completed by a specialist and not a general practitioner and for use in a disability claim only.

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.

Guidelines : Medical Report on Functional Impairment *(only for a disability claim)*

Please use the following only as a guideline to compile your report. *for use in a disability claim only*

- 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 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)
Psychiatric	Social functioning, concentration, psychometric tests in cases of cognitive impairment.

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