Disability Claims

Category A members

The following Alexander Forms Heath Management Services forms must be completed:

- Confidential medical report – Mental and behavioural conditions - to be completed by treating physician)
- Confidential medical report - to be completed by the treating physician.
- Consent form for disability and incapacity – to be completed by the member.
- Employee statement – to be completed by the member.
- Employer statement – to be completed by employer Forms to be submitted to Alexander Forbes Health Management Solutions - SachsM@aforbes.com

Category B and C members

The following Sanlam forms and documents must be completed and submitted with a claim for a disability benefit:

- Declaration by employer
- Particulars of the insured's occupation
- Declaration by insured.
- Confidential medical report – *Attached Confidential Medical Report to be completed by insured's treating specialist (or GP, if no specialist is treating the insured). Form EB2880E attached. If the doctor provides a typed report, the guidelines on page (13) apply.*

The following documents must also be submitted together with the claim forms to Sanlam:

- Leave records – Please provide copies of all leave records for the past 12 months. *Sick leave should be clearly marked.*
- Salary statement – *Please provide a copy of the insured's salary statement as of 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 year's salary statements.
- Identity document – *Please provide a copy of the insured's identity document.*
- Job description – *Please provide a comprehensive (typed) copy of the insured's job description at the time of disability.*

Forms are to be submitted to: sgrdisabilityclaims@sanlam.co.za

CONFIDENTIAL MEDICAL REPORT (CMR)

Please note that since the onus is on the member to prove disability, the costs of this report and/or evaluation is that of the member. Hence, kindly submit the account to the member directly. **ALEXANDER FORBES HEALTH MANAGEMENT SOLUTIONS IS NOT RESPONSIBLE FOR THIS ACCOUNT**

Date(s) of consultation	
Name of Employee	

Diagnosis (and underlying medical conditions)	
If Psychiatric Multi-axial Diagnosis	Axis I : Axis II: Axis III: Axis IV: Axis V:

History of the current condition (including any hospital admissions)	

Current clinical examination								
Appearance								
Height		Weight		BMI				
Vital signs (if applicable)			BP		Pulse Rate		Respiratory Rate	
Range of motion, please record restricted movements of joints only								
Standing tolerance (in minutes)				Sitting tolerance (in minutes)		Walking tolerance (in meters)		

Posture	
Balance	
Sensation	
Mobility	Bed Mobility
	Squatting
	Kneeling
	Sitting to standing
	Climbing stairs
Muscle strength/ power (comment on affected muscle groups only)	
Hand function (if applicable)	
Straight leg raises	
Reflexes	
Impairments in activities of daily living	- Self-care - Driving/ travel - Home maintenance - Vocational activities

TREATMENT			
Type	*Nature of Surgery*	*Date(s)*	*Response*
Surgery			
Pharmacology			
Rehabilitation (please tick)	Physiotherapy		
	Occupational Therapy		
	Psychotherapy		
Other			

Investigations (Kindly attach reports for investigation results e.g. pathology and radiology reports)			
Type	*Date(s)*	*Result(s)*	
X-rays (specify area)			
Blood tests, e.g. FBC, Cd4 count, viral load			
Other, e.g. sputum test			
Compliance			
Recommended future treatment			
Prognosis		Influencing factors	
Has there been deterioration or an improvement in the claimant's condition over time?		Please elaborate	
Please comment on any other medical condition the claimant may be experiencing, either as a result of or independent of the member's condition:			

When is the member expected to return to work?	

MEDICAL PRACTITIONER				
Name		Practice Number		
Qualification		Phone Number		
Address			Code	
Email		Fax Number		
Signature		Date		

DISABILITY AND INCAPACITY CONSENT FORM

Company Name:

Name of employee:

Surname of employee:

Date of birth / ID number of employee:

Employee Reference number:

Fund Name:

I _____ hereby give my informed, voluntary consent and authorize Alexander Forbes Health Management Solutions, the Insurer and the Trustees of the Fund to obtain and review any medical information from any medical practitioner, medical institution or any other person(s) who may be in possession of my medical information; or obtain any further information from my employer and/or any other person for purposes of processing an incapacity or disability claim.

Alexander Forbes may be required to share medical and personal information with an Independent medical specialist appointed by Alexander Forbes Health Management Solutions for the same reason.

I understand that my right to privacy is curtailed to the extent permitted by me in this authorisation. I also understand that I am under no obligation to consent to the disclosure of the information referred to herein and that I have the right to refuse to sign this Consent Form. Alexander Forbes Health Management Solutions and Vrystaat Munisipale Pensioenfomds endeavours to ensure all information is kept confidential according to the POPI Act.

I understand that I do have the right to withdraw this consent at any time in writing to Alexander Forbes Health Management Solutions and (client). I acknowledge that I am aware that should I withdraw my consent no potential benefit may be paid.

I hereby indemnify Alexander Forbes Health Management Solutions and Vrystaat Munisipale Pensioendfonds against any claim of whatever nature, arising out of or in connection with the furnishing of medical information as contemplated in this Consent Form.

This consent form will automatically become null and void upon:

- Leaving the employ of my current employer
- Death, once the process is finalised

I confirm that a copy of this consent shall be as effective and valid as the original.

SIGNED AT: _____

THIS _____ DAY OF _____ 20 ____

SIGNATURE: _____

_____ _____

COMPANY WITNESS 1 **WITNESS 2**

CONFIDENTIAL MEDICAL REPORT (CMR)

Please note that since the onus is on the member to prove disability, the costs of this report and/or evaluation is that of the member. Hence, kindly submit the account to the member directly. **ALEXANDER FORBES HEALTH MANAGEMENT SOLUTIONS IS NOT RESPONSIBLE FOR THIS ACCOUNT**

Date(s) of consultation	
Name of Employee	

Multi-axial Diagnosis	Axis I : Axis II: Axis III: Axis IV: Axis V:

Kindly provide a psychiatric history	

Current clinical examination	
Appearance	
Current complaints and symptoms	

Clinical findings	
Impairments in activities of daily living	- Self-care - Driving/ travel - Home maintenance - Vocational activities (work)

Treatment, including response to treatment			
Past treatment			
Current treatment			
Pharmacology			Response:
Rehabilitation (please tick)	Physiotherapy		Response:
	Occupational Therapy		
	Psychotherapy		
Recommended future treatment			

Is the claimant complaint to treatment?	
Do you consider treatment to be optimal? If not, kindly elaborate	

Investigations, if applicable (Kindly attach reports for investigation results e.g. pathology and radiology reports)		
Type	*Date(s)*	*Result(s)*
X-rays (specify area)		
Blood tests, e.g. FBC, CD4 count, viral load		
Other, e.g. sputum test		

Prognosis	
Prognosis and influencing factors	
Has there been deterioration or an improvement in the claimant's condition over time? Please elaborate	
Please comment on any other medical condition the claimant may be experiencing, either as a result of or independent of the	

member's described condition	
When is the member expected to return to work?	

MEDICAL PRACTITIONER				
Name		Practice Number		
Qualification		Phone Number		
Address			Code	
Email		Fax Number		
Signature		Date		

EMPLOYEE STATEMENT

Name and surname of claimant	
Date of birth	
Name of Company	
Company/Employee Reference number	
Fund Name	

I, _____ being aware of my rights pertaining to privacy of my medical records and or information, do hereby give my informed consent and hereby authorise any medical practitioner, hospital, employer or other person to furnish Alexander Forbes Health Management Solutions and the Insurer with any information relating to my illness or injury. I further authorise the Insurer to gather information regarding my employment. I also hereby authorise the Insurer to release the aforementioned information to other parties involved in the claim. I hereby declare and warrant that the answers given by me in this claim form are, in every respect, true and correct, and that no material information has been withheld nor relevant circumstances omitted.

_____ _____

DATE **SIGNATURE**

Details of member:

Physical Address of member:

Postal Address

Email Address

Residential telephone number

Work telephone number

Cellphone number:

Language spoken:

Gender:

Male		Female	

Medical Aid Details

Income tax number

Were previous applications submitted?

Yes		No	

If yes, please provide details:

Details of next of kin:

Name and surname

Relationship

Residential telephone number

Work telephone number

Cellphone number:

Occupation Details:

What is your current status of employment?

- ☐ Working full time
- ☐ Working part-time/reduced hours
- ☐ Contract worker
- ☐ Sick leave
- ☐ Unpaid leave
- ☐ Laid off/ dismissed
- ☐ Other

What is your current occupation?

What are your main duties of your current occupation? Please provide details of your duties

When did were you appointed/employed to perform your current occupation

Y	Y	Y	Y	M	M	D	D

When were you last able fulfil your normal duties:

Y	Y	Y	Y	M	M	D	D

What other jobs may you be able to do given your qualifications and work experience and despite your limitations?

When do you expect to take up any occupation in the future?

Y	Y	Y	Y	M	M	D	D

Education:

Year	Standard/Degree	School/Institution

In house training:

Year	Qualification	School/Institution

Employment History (full history),

Year	Employer	Job Title	Description of job	Reason for leaving

Medical information:

Which illness/impairments/injury causes your inability to work?

What are your lists of complaints/symptoms?

When did you first start experiencing your symptoms?

Y	Y	Y	Y	M	M	D	D

When did the symptoms start affecting your ability to perform your job?

Y	Y	Y	Y	M	M	D	D

Which activities are affected by illness/impairment/injury – personal management, driving, leisure?

How do you spend your day currently?

Current treatment and list medication

Details of your treating general practitioners/Specialists/therapists:

Name of doctor	**Speciality**	**Since when have you been consulting this doctor**	**Contact details (telephone number, physical address hospital name)**

Details of your hospitalisation:

Date Admitted	Hospital	Treating Doctor and contact number	Reason for admission	Date discharged

Other income details:

Income details and other incomes

	Workman's Compensation	Pension or Provident Fund	Disability Policies arranged by Employer	Disability Policies arranged by Yourself
Estimated Amount Of Benefit				
How Is Benefit Payable, e.g. Monthly, Lump Sum				
Date Benefit Is Or Becomes Payable				
For How Long Is The Benefit Payable?				

EMPLOYER STATEMENT

Name and surname of claimant	
Date of birth / **ID Number**	
Name of Company	
Company/Employee Reference number	
Fund Name	

Details of Employer

Name of Employer/Company name:

Name of contact person at the Employer/Company:

Designation of the contact person:

Physical Address of Employer

Postal Address of Employer:

Telephone number of Employer

Fax number of Employer

Email address of Employer

Members Details:

Date joined Company

Y	Y	Y	Y	M	M	D	D

Date joined Fund

Y	Y	Y	Y	M	M	D	D

Member's current occupation (Please attached job description):

Job Category (please tick):

- ☐ Managerial
- ☐ Supervisory
- ☐ Driver
- ☐ Clerical
- ☐ Machine operator (e.g. driving or using a machine to perform a task)
- ☐ Light Manual work (physically packing or sorting)
- ☐ Heavy Manual work (physically digging or loading)

Kindly list the main duties of the member's current occupation:

When did the claimant start the above occupation?

Y	Y	Y	Y	M	M	D	D

On what day was the member last able to perform all the duties of the above occupation due to his/her medical records (please attached the sick leave records) :

Y	Y	Y	Y	M	M	D	D

Was the member working a full day on the last day of work?

Yes		No	

If not, please provide details:

Date of which the member returned to work (if he/she returned to work after receiving disability benefits)

Y	Y	Y	Y	M	M	D	D

Please describe the minimum physical abilities that a healthy individual requires to do this job:

Strength	**How Much?**	**What?**
Lift - kilograms		
Carry – kilograms / metres		
Push – kilograms / metres		
Pull – kilograms / metres		
Hold - kilograms / metres		
Endurance	**How Much?**	**What or where?**
Climb - metres		
Stoop – percentage of day		
Stand- percentage of day		
Sit - percentage of day		
Walk – smooth terrain	Metres per day	
Walk – uneven terrain	Metres per day	
Accuracy	**How Much?**	**What?**
Fine precise movements		
Control of tools		
Use of both hands		

Please describe the minimum mental abilities that a healthy individual requires to do this job

	Very often	**Often**	**Seldom**
Literacy			
Numeracy			
Memory			
Problem solving			
Decision making			
Specialised knowledge			
Speaking			
Writing			
Listening			
Reading			
Public speaking			

To what extent does the member have to cope with the following demands on his/her body?

	All the time	**Most of the time**	**Some of the Time**	**Never**
Jarring				
Cold				
Heat				
Noise				
Dust				
Fumes				

2.3 In which of the following environments does the claimant perform his duties:

	All the time	**Most of the time**	**Some of the Time**	**Never**
Outdoors				
Indoors				
Heights				
At Depths				

What are the working hours per day?

Is the member required to work shifts?

Yes		No	

Have there been any attempts to adapt the member's work environment to accommodate the impairments?

When were these accommodations implemented?

Why were these accommodations not successfully?

Have there been any attempts to realign the member in an alternative occupation?

When was the member realigned?

Why was this realignment not successful?

What other alternative jobs within the Company/Organisation would the member be capable of performing?

Only complete this section if driving is a component of the member's job:

Licence code/s required	
Type of vehicle/s driven	
Average distance driven per day km	
Per week km	
Per month km	

DECLARATION

I hereby declare that, to the best of my knowledge, the particulars above are true and complete. I hereby authorise that the information can be forwarded to Alexander Forbes Health Management Solutions, the insurer and the trustees of the fund.

COMPANY STAMP

SIGNATURE: _____
NAME (please print): _____
OFFICIAL TITLE: _____
DATE _____

Claim for Lump sum disability benefit and/or monthly disability income benefit

Protection of Personal Information Disclosure

Why Personal Information is required: Sanlam Life Insurance Limited ("Sanlam Life"), a subsidiary of Sanlam Limited, will process and protect your personal information as required by relevant laws and the Constitution of the Republic of South Africa ("RSA"). The personal information requested in this form, which may include special personal information is being collected and will be processed for the following purposes:

- underwriting and providing accurate and effective insurance cover and related value-added services;
- member communication;
- market research and statistical analysis;
- verification of the personal information provided;
- to comply with all legal and regulatory requirements, including applicable codes of conduct;
- to protect Sanlam Life's interests; and
- any purposes related to the above.

Failure to provide the mandatory information will prejudice your insurance cover.

Changing and correcting Personal Information: You have the right to:

- Request a copy of your personal information as processed by Sanlam Life;
- Ask for an update and/or correction of your personal information;
- Lodge a complaint with the Information Regulator.

Sanlam Life may charge an administrative fee subject to prior notice of any such cost before executing the request for a copy of your personal information.

Other parties that may receive the Personal Information:

- We may share your personal information within Sanlam Limited and/or with other service providers where required for any of the purposes listed above, or with third parties where Sanlam Life is lawfully required to do so.
- We may send your personal information to service providers outside the RSA for storage or further processing on Sanlam Life's behalf. We will not send your information to a country that does not have information protection legislation similar to that of the RSA, unless we have a binding agreement with the service provider which ensures that it effectively adheres to the principles for processing of personal information in accordance with the Protection of Personal Information Act, 2013.

For more information, please refer to the Sanlam Group Privacy Notice.

Print form Save form

Claim for Lump sum disability benefit and/or monthly disability income benefit

1 Contents

It is important that you complete the forms in detail. The answers you provide will help us understand the illness/injury that is causing the absence from the workplace and will help to avoid delays in the processing of the claim.

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

- **Declaration by employer**
- **Particulars of the insured's occupation**
- **Declaration by insured**
- **Confidential medical report:** *Attached Confidential Medical Report to be completed by insured's treating specialist (or GP, if no specialist is treating the insured). Form EB2880E attached.*
  If the doctor provides a typed report, the guidelines on page (13) apply.

The following documents must also be submitted together with the claim forms to Sanlam.

- **Leave records: Please provide copies of all leave records for the past 12 months.** *Sick leave should be clearly marked.*
- **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 year's salary statements.
- **Identity document:** *Please provide a copy of the insured's identity document.*
- **Job description:** *Please provide a comprehensive (typed) copy of the insured's job description at the time of disability.*

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 Sanlam may reasonably require.

3 Disclaimer

In line with the FIC Amendment Act, 2017 and other Party Due Diligence requirements, Sanlam has the obligation to identify and verify all persons or entities we interact with. Thus, please provide the information as requested in the forms.

Sanlam reserves the right to cancel the insurance immediately if any of the obligations in terms of the FIC Amendment Act, 2017 and other Party Due Diligence requirements are not met.

The employer must please either post, fax or e-mail the duly completed forms to:

Sanlam Corporate: Group Risk Disability Claims (7709)
PO Box 1
Sanlamhof
Bellville
7532

Fax number (021) 947-3207
E-mail address sgrdisabilityclaims@sanlam.co.za

Declaration by employer *(To be completed by the employer)*

A Particulars of fund/scheme

Name of fund/scheme _____ Code _____

Name of branch/participating employer _____

E-mail address _____

Telephone number ( ) _____

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-habiting ☐ Widowed ☐

Identity number _____

Educational qualifications _____

Further courses/training completed _____

_____

Particulars of membership

Membership no. _____ Pay-sheet no. *(If any)* _____

Date of entering service _____ Date of permanent appointment _____

Date of commencement of membership _____

If the scheme has been underwritten by Sanlam for less than 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 was covered at the previous insurer? _____

Salary information for the past 3 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 Sanlam, 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 *(dd/mm/ccyy)*	Amount of medical aid premium * (R)
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 Sanlam 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 by the employer 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 supervisor _____

Telephone number of supervisor (_____) _____

Email address of supervisor _____

Name of contact person at Human Resources Department _____

Telephone number of contact person (_____) _____

Email address of HR contact person _____

Insured's occupation _____

Prior to his/her current work absence, how much time has the insured been off work due to sickness in the past 12 months?

Please state approximate number of days/weeks: _____ days / _____ weeks

Please list the insured's main duties:

Task	Weight (%)	Present ability to perform tasks		
		Able	Partially able	Unable
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
	100%			

Please list the insured's job demands and job category in their current occupation

Job demands	%
Physical	
Supervisory	
Administrative	
Total	100%

Job category	
Manager	☐
Supervisor	☐
Clerical	☐
Machine operator	☐
Light manual labourer	☐
Heavy manual labourer	☐
Other:	

Particulars of insured's occupation *(continued)*

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)*

Has a return to work date been discussed/agreed? Yes ☐ No ☐

If "Yes", please provide details _____

How often are you in contact with the insured ? _____

Was the insured considered for any other position in the organisation? Yes ☐ No ☐

If "Yes", provide the following particulars:

In which capacity? _____

Description of work _____

Accommodated work duties _____

Please provide a description of the accommodated duties.

Working hours _____ Working environment _____

From which date? _____ Until which date? _____

Is the status of the position: Higher ☐ Equal ☐ Lower ☐ than the previous position?

Average remuneration per month in this position: R _____

Particulars of insured's occupation *(continued)*

Did the insured accept the position? Yes ☐ No ☐

If "No", please provide reasons: _____

_____

If insured could not be considered/placed elsewhere, please give reasons:

_____

_____

_____

Were/are there any other factors or reasons impacting on the insured's absence – e.g. workplace issues, disciplinary, family circumstances etc? Yes ☐ No ☐

If "Yes", please provide brief details _____

_____

_____

Signed by employer on behalf of the fund/scheme, *(by the insured's manager, supervisor or any other person who is familiar with the circumstances).*

Initials and surname _____

Designation _____

Signature _____

Place _____

Date _____ *(dd/mm/ccyy)*

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

Title _____ Full names _____

Surname _____

Previous name *(if applicable)* _____

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

Country of birth _____

Type of identification Identity document* ☐ Passport ☐ *copy of applicable document compulsory*

Number _____ Country of issue _____

Passport expiry date _____ *(dd/mm/ccyy)*

**Provide a copy of your Identification document or Identification Smart card (copies of both sides)*

Country and/or Country of citizenship/Nationality RSA ☐ Other country Yes* ☐ No ☐

* If "Yes", please give other country _____

Address and contact numbers:

Residential address _____

_____ Postal/Zip code _____

Postal address *(if it differ from the residential address)* _____

_____ Postal/Zip code _____

Cell/Mobile _____ Other contact number (h) _____ (w) _____

e-mail address _____

Next of kin contact details:

Title _____ Full names _____

Surname _____

Relation: _____

Contact number ( ) _____

Email address: _____

1(a) Educational History

Highest school qualification _____

Other training/qualifications _____

_____

_____

1(b) 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 *(dd/mm/ccyy)*	Period in service/ To *(dd/mm/ccyy)*	Nature of work	Reason for leaving

1(b) Occupational history *(continued)*

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

2 Nature of disability

- What do you believe to be the cause of your illness/injury?
- Please describe the symptoms you are experiencing, including how often and how it affects your ability to work.
- Since when (date) were you experiencing difficulties to perform your job? _____ *(dd/mm/ccyy)*
- On what date did you last actively practice your occupation? _____ *(dd/mm/ccyy)*
- Have you been able to perform any other occupations or functions since you first became disabled? Yes ☐ No ☐

  If "Yes", please describe these functions.
- I do think I will be back to my normal work within 6 months.

  ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

  What would need to change, and what assistance would you need, in order for you to return to work?

  Please also advise whether you have discussed this with your employer Yes ☐ No ☐
- Based on your experience and training, what other occupations can you perform?
- Is it important to you to go back to work in the future?

  ☐ Exactly true ☐ Moderately true ☐ Hardly true ☐ Not at all true
- I am afraid that going back to work will worsen my health condition.

  ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

3 Medical care

- What is the main cause of your disability?
- Since what date did you experience the symptoms? _____ *(dd/mm/ccyy)*
- On what date did you see the doctor about this for the first time? _____ *(dd/mm/ccyy)*
- How many times have you seen your General Practitioner (GP)/main treating doctor in the past 12 months (for your own health)?

  Please state approximate number of visits: _____

3 Medical care *(continued)*

- What treatment have you received (include treatment type and frequency)

- Please provide us with a list of your current medication and dosages

Medication	Dosage

- Do you suffer from any other medical conditions? Yes ☐ No ☐

  If "Yes", please provide details

- Provide the names and contact details of doctors/specialists/therapists consulted in this regard and provide details:

Name of doctor(s)/specialists/therapist consulted	Profession	Contact number(s)	e-mail address

- How are you coping with this health problem?

  ☐ I'm coping very well ☐ I'm coping well ☐ I'm not coping so well ☐ I'm not coping well at all

- How do you spend your days?

- What day-to-day activities that you used to be able to do, are you struggling to do, or are you unable to do, as a result of your illness/injury?

- I have people (family, friends, neighbours, colleagues and/or others) who I can count on when I need help or support.

  ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

4 Disability due to an accident

- If your disability was caused by an accident, please give the following information:

  Circumstances causing the accident

  Date of accident _____ *(dd/mm/ccyy)*

  If a formal enquiry was conducted, please state by whom and what the result was *(include a copy of the accident report)*

5 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? Yes ☐ No ☐
  (Including income from any employer, partner, assurance company, a pension or retirement annuity fund, RAF, COIDA, any governmental fund or any other source.)

  If "Yes", please give the following details:

  Regular amounts *(including life annuities)*

Source of benefit	Amount (R)	Commencement date of payment *(dd/mm/ccyy)*	Date of cessation *(dd/mm/ccyy)*

  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 *(dd/mm/ccyy)*

- Tax particulars

  Income tax reference number _____

  Income tax office to which last return was rendered _____

  Do you perform any other work for income? Yes ☐ No ☐

  If "Yes", please describe in detail _____

  _____

  Do you have any business registered in your name. Yes ☐ No ☐

  If "Yes", please complete the following:

Name of business	Type of business	Date of registration (dd/mm/ccyy)	Role of the business

6. Banking details

Please provide us with proof of the banking details for the account holder from the bank as well as the following information:

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current ☐ Savings ☐ Transmission ☐

7 Disclaimer

In line with the FIC Amendment Act, 2017 and other Party Due Diligence requirements, Sanlam has the obligation to identify and verify all persons or entities we interact with. Thus, please provide the information as requested in the forms.

Sanlam reserves the right to cancel the insurance immediately if any of the obligations in terms of the FIC Amendment Act, 2017 and other Party Due Diligence requirements are not met.

8 Consent for Disclosure of Confidential Information and Declaration

I, _____ *(full name(s) and surname of insured)*

(Identity number) _____ hereby voluntarily grant authorisation to medical practitioners to disclose my medical and personal records to the medical practitioners appointed by Sanlam to assess (and review) my disability. This includes my previous medical history as well as any psychological or psychiatric records for the purpose of determining my ability to perform work.

I also declare that I have no objections to my medical information being supplied to and obtained from, either directly or through a data base operated by or for insurers as a group, Sanlam's medical advisor, the employer, fund, ombudsman, legal representatives, other insurers, reinsurers and/or the medical service providers involved in the disability assessment and rehabilitation processes if necessary, for the purposes of underwriting risks or assessment and review of any claim for benefits under a policy.

I also irrevocably authorise any medical practitioner, medical specialist, health professional, hospital, medical scheme, or any other person or institution who may be in possession of or who may later obtain possession of any information regarding my health, whether such information pertains to the past or to the future, to disclose such information to Sanlam and I agree that this authorisation will also remain in force even after my death.

I accept and understand that I am limiting my right to privacy to the extent permitted by me in this authorisation, to facilitate the validation and assessment (and review) of my disability claim under the group insurance policy, or any other reason including detection and prevention of fraudulent claims. I acknowledge that I cannot cancel this authorisation and that it will endure even after my death.

I will not hold Sanlam and/or its directors, agents, intermediaries and/or employees liable for any consequences that may arise as a result of such sharing/disclosure and/or collection of my personal information.

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

Completed and signed at _____ on this _____ day of _____ 20 _____

Signature of insured _____

Full name(s) and surname of witness _____

Signature of witness _____

Guidelines for a confidential medical report

Important: The examination and compiling of a medical report must be done by the patient's treating specialist. Only if there is no treating specialist attending to the insured, may a general practitioner complete the report.

Dear Doctor,

Sanlam 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.

Please complete the attached Confidential Medical Report form. If you choose to submit a typed report, then the guidelines below apply.

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.

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. Please provide a detailed description.
- Treatment
  - Treatment modalities
  - Types of medication and dosage
  - Duration of treatment
  - Therapeutic procedures
  - Rehabilitation
  - Hospitalisation
  - Dates of consultations
- Response to treatment and side effects
- Compliance with treatment
- Complications that are permanent
- Special investigations (e.g. ECG, X-rays, scans, blood tests, laboratory test results, etc.)
- 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, echocardiogram, 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 (eg. nerve conduction tests)
  - Neurological: MRI, CAT scan results, EKC other
  - Surgery: Surgical report
  - Psychiatric: social functioning, concentration, psychometric tests in cases of cognitive impairment, frequency and dates of consultations
  - Immunocompromised conditions: blood tests, CD4 count and viral load

Print form Save form

EB2880E

Confidential Medical Report: Disability

Dear Doctor,

Thank you for your time.

We request your assistance with getting a better understanding of the claimant's medical condition to support his/her claim for disability benefits. Your thorough completion of this document will help to expedite our assessment process.

Please note that the cost of completion of this report is for the policyholder's account.

Kindly return the completed report with copies of all relevant clinical or diagnostic tests results or any additional medical information you have available, to sgrdisabilityclaims@sanlam.co.za

Please see the attached Guideline document (page 6).

Scheme and personal details

Name of fund/scheme _____

Name of employer _____

Name of insured _____

Insured's date of birth _____ Identity number _____

Membership number _____

Medical practitioner information

Full names and surname _____

Address _____

_____ Postal code _____

Email address _____

Qualification: _____

Practice number _____ Contact telephone number _____

1. Course of illness

Since when has the claimant been your patient? _____ (ddmmccyy)

Most recent examination date _____ (ddmmccyy)

Previous consultations:

Date *(ddmmccyy)*	Diagnosis	Treatment

When was the diagnosis first made? _____ (ddmmccyy)

When did the symptoms present the first time? _____ (ddmmccyy)

Current complaints from the claimant's point of view:

_____

_____

_____

After consultation, what symptoms does the claimant currently present with? (list all):

What permanent complications of the condition have you identified?

Specialist consultations and special investigations done:

Specialist or investigation done	Date (ddmmccyy)	Result

Very important: *If you have any specialist reports/psychiatric reports/special investigations (e.g. X-rays, scans, ECGs, lungfunction tests, histology reports, etc), please supply copies.*

Current medical examination:

Weight: _____ Height: _____ BP: _____

Pulse: _____ Cholesterol: _____ Blood glucose: _____

2. Treatment

Current medication

Name/type	Dosage	Duration

Previous medication

Name/type	Dosage	Duration

Other forms of treatment (e.g. physiotherapy, rehabilitation, surgery, ECG or psychotherapy)

Type	Name and contact of doctor/therapist	Period of treatment

Please comment on the claimant's compliance to treatment/medication:

Do you consider this treatment optimal? If not, please elaborate:

3. Prognosis

Please give your opinion on the prognosis:

Since when has the claimant been unable to perform the tasks of his/her regular occupation due to his/her condition?

Will further treatment, rehabilitation or work modification lead to improvement of the claimant's ability to function? Please elaborate.

When, in your view, will the insured be able to resume his/her employment or any part thereof?

Full time _____ Part-time _____

4. Functional impairment

In order to determine the claimant's functional ability to pursue a specific occupation, would you please indicate to what extent he/she can carry out the activities listed in the table below. If possible, these abilities should be weighed relatively as it would have been if he/she did not have the injury/illness. The claimant's age, intelligence or natural capabilities should not be considered.

Activity/task or function	**Please describe the claimant's ability to carry out the task e.g.** Impossible, possible with much/little pain/discomfort, dangerous to himself/herself/ others, no limitations, etc.	**Will this capability most likely:** improve, worsen or remain constant**?**	**If possible, please estimate period over which change will occur.** (weeks/months/ years)
Clerical or administrative work (sedentary occupation)			
Concentration			
Memory			
Interaction with others (colleagues, clients, etc.)			
Supervisory work			
Sit continuously for more than an hour			
Sit continuously for less than an hour			
Stand continuously for more than an hour			
Stand continuously for less than an hour			
Walks (minimal effort) on level ground			
Walks(with effort) on uneven ground			
Bend, crouch, kneel, crawl, balance			
Climb steps/ladder			
Handling of heavy objects (more than 10kg)			
Handling of light objects (less than 5kg)			
Handling of heavy machinery			
Handling of light machinery			
Fine manual work (e.g. writing, typing, small electrical repairs)			
Driving of heavy vehicle			
Driving of light vehicle			

Additional questions

5. Claimant's co-operation/motivation (e.g. with regards to medication, smoking, weight loss):

6. Other factors that might influence the insured's ability to work (e.g. alcohol, drug dependence, motivation, social problems, conflict with colleagues at present workplace):

7. Please provide any other information that may assist Sanlam in assessment of this claim:

Signature of medical practitioner _____

Date _____ (ddmmccyy) Place _____

Please provide practice stamp