



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

1 Contents

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 fund/scheme**
- **Particulars of the insured's occupation**
- **Payment of benefits**
- **Declaration by insured**
- **Confidential medical report:** *Report to be compiled by insured's treating specialist according to the guidelines attached. (See page 12).*

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

- **Sick leave records:** *Provide copies of all sick leave records for the past 12 months.*
- **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.*

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.

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

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

Fax number (021)947-3207

E-mail address Disabilityclaimbenefits.EB@sanlam.co.za

Please note: To obtain an Afrikaans version of the claim documents, contact Sanlam Group Risk at the address provided above.

Declaration by fund/scheme *(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 _____

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 received cover at the previous insurer? _____

Salary information for the past 3 years

Date of salary received	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	Amount of medical aid premium *
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 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 () _____

Name of contact person at Human Resources Department _____

Telephone number of contact person () _____

Insured's occupation _____

Please list the insured's main duties:

Duty	Weight (%)	Present ability to perform duties		
		Able	Partially able	Unable
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	100%			

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

Job demands	%	Job category	
Physical		Manager	<input type="checkbox"/>
Supervisory		Supervisor	<input type="checkbox"/>
Administrative		Clerical	<input type="checkbox"/>
Total	100%	Machine operator	<input type="checkbox"/>
		Light manual labourer	<input type="checkbox"/>
		Heavy manual labourer	<input type="checkbox"/>
		Other:	

Please list the physical aspects of the occupation

Movement	%Time spend				Comments
	None	Occasionally 0-33%	Frequently 34-67%	Majority 68-100%	
Weight handling:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maximum weight:
- Lift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maximum weight: Kilogram
- Carry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maximum weight: Kilogram
- Push or pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maximum weight: Kilogram
- Throw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maximum weight: Kilogram:
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
- Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
- Ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fine precision work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Particulars of insured's occupation *(continued)*

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)*Did he/she do other work thereafter? Yes No

If "Yes", provide the following particulars:

In which capacity? _____

Description of work _____

From which date? _____ Until which date? _____

Educational qualification of insured _____

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

If "Yes", please answer the following questions.

In what capacity? _____

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

Average remuneration per month in this position: _____

Did the insured accept the position? _____

If not, please provide reasons: _____

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

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

Initials and surname _____

Designation _____

Signature _____

Place _____

Date _____ *(dd/mm/ccyy)*

Payment of benefits

Important: The person who completes this part of the form, must familiarise themselves with the disability benefit/s the insured is/are covered for in terms of the policy agreement. Should the claim for the disability benefit/s become payable (after applying the waiting period and other policy payment stipulations) Sanlam will rely on the information provided in the applicable section/s of the form.

Submitting incorrect or insufficient information can lead to incorrect and/or delayed payment of the disability benefit/s.

The information supplied will only be used once the claim has been admitted.

Mark the applicable option with an 'X'

While the insured is absent from the workplace, will the insured still receive a monthly salary? Yes No

If answered "Yes" until when will the insured receive a monthly salary? _____ (dd/mm/ccyy)

If answered "No" until when will the insured receive a monthly salary? _____ (dd/mm/ccyy)

Please confirm the insured's last date of performing his/her duties _____ (dd/mm/ccyy)

Note: Only complete the payment instruction sections based on the applicable disability benefits the insured is/are covered for in terms of the policy agreement.

Lump sum disability benefits payable to the fund in terms of the policy agreement:

Please provide the banking details of the fund.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

Lump sum disability benefits payable to the insured in terms of the policy agreement:

Please provide the banking details of the insured.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

Salary Refund disability benefit payable to the employer in terms of the policy agreement:

Please provide the banking details of the employer.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

Payment of benefits *(continued)***Spouse or Accident benefits payable to the spouse/insured in terms of the policy agreement:**

Please provide the banking details of the spouse/insured.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

Note: *The policy agreement provides for Income Continuation disability benefit, Income Care disability benefit, Top Up disability benefit and the Medical Aid Premium Waiver benefit. It is possible that an insured may be covered for more than one of the benefits. Please complete the applicable sections and provide the necessary banking details.*

Income Continuation disability benefit/Income Care disability benefit payable to the employer in terms of the policy agreement:

Please provide the banking details of the employer.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

E-mail address where payment advice must be sent to _____

Name and surname _____ Telephone number (_____) _____

Income Continuation disability benefit/Income Care disability benefit payable to the insured in terms of the policy agreement:

Please provide the banking details of the insured.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

Note: *If the policy agreement makes provision for the payment of employer (company) contributions, please complete this sections and provide the banking details of the fund - if payable to the fund, or the employer's - if payable to the employer.*

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

E-mail address where payment advice must be sent to _____

Name and surname _____ Telephone number (_____) _____

Payment of benefits *(continued)*

Note: *If the insured, before he/she became disabled, paid member contributions to the fund, Sanlam can continue deducting the contributions from the insured's monthly disability benefit and pay it to the fund. Deducting such contributions is however not in terms of the policy agreement and therefore the insured's prior consent is required.*

Please provide the member contributions percentage, to be deducted from the insured's monthly disability benefit and the banking details of the fund.

Member contribution percentage (_____)%

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

E-mail address where payment advice must be sent to _____

Name and surname _____ Telephone number (_____)

Top Up benefit payable to the employer in terms of the policy agreement:

Please provide the banking details of the employer.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

E-mail address where payment advice must be sent to _____

Name and surname _____ Telephone number (_____)

Top Up disability benefit payable to the insured in terms of the policy agreement:

Please provide the banking details of the insured.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

Medical Aid Premium Waiver benefit payable to the employer in terms of the policy agreement:

Please provide the banking details of the employer.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

E-mail address where payment advice must be sent to _____

Name and surname _____ Telephone number (_____)

Payment of benefits *(continued)***Medical Aid Premium Waiver benefit payable to the medical aid scheme:**

Please provide the banking details of the medical aid scheme.

Name of member's medical aid scheme _____

Medical aid membership number _____

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current Savings Transmission

E-mail address where payment advice must be sent to _____

Name and surname _____ Telephone number (____) _____

Important: *In terms of the policy agreement, premiums in respect of the insured's benefit/s is/are still payable.*

Declaration

We, the undersigned, declare on behalf of the fund/scheme, that the information provided above is complete and correct.

Signed on behalf of the fund/scheme

Initials and surname _____ Initials and surname _____

Designation _____ Designation _____

Signature _____ Signature _____

Place _____ Date _____ (dd/mm/ccyy)

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

Name of insured _____

Date of birth _____ Identity number _____

Telephone number (____) _____ Cell phone number _____

E-mail address _____

Postal address _____

Postal code _____

Residential address _____

Postal code _____

1 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	Period in service/ To	Nature of work

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

2 Nature of disability and medical care

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

- Circumstances causing the accident.

- If a formal enquiry was conducted, please state by whom and what the result was.

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

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

- If "Yes", please give the following details:

Regular amounts *(Including Life annuities)*

Source of benefit	Amount (R)	Commencement date of payment	Date of cessation

3 Income (continued)

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

Tax particulars

Income tax reference number _____

Income tax office to which last return was rendered _____

4 Declaration

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

Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks and the consideration of any claim for benefits under a policy related to this or any other proposal for insurance made by me, or in respect of me as insured, I irrevocably authorise Sanlam to:

- Obtain from any person whom I hereby so authorise and request to give any information which Sanlam deems necessary.
- Share with other insurers that information contained in this proposal or in any related policy 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 or by the operators of such data base.

Signature of insured _____

Name and surname of insured _____

Witness _____

Date _____ (dd/mm/ccyy)

Place _____

Important: The examination and compiling of a medical report must be done by the patient's treating specialist and cannot be performed by a general practitioner.

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.

The assessment of a disability claim is based on the principals of **functional impairment** and **disability**. It is important that you are aware of our distinction between the two principles.

- **Functional impairment** is determined by using a medical diagnosis of the functions a person is able to perform and the functions that can no longer be performed.
- **Disability** is determined through a legal process that assesses the extent of a person's functional impairment, judged in conjunction with his/her job description, the policy conditions and personal factors such as education, experience, etc. (This decision will be made by Sanlam Life Insurance Ltd.)

Kindly supply Sanlam with a report, along the guidelines provided below, after you have examined and assessed the **functional impairment** of the patient.

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 for psychiatric conditions)
- Date of onset and course of disease
- Severity Perpetual factors, secondary gain
- Current clinical findings. Detailed description
- Treatment
 - Treatment modalities
 - Types of medication and dosage
 - Duration of treatment
 - Therapeutic procedures
 - Rehabilitation
 - Hospitalisation
- Response to treatment
- Complications that are 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 (eg. nerve conduction tests)
 - Psychiatric: social functioning, concentration, psychometric tests in cases of cognitive impairment