

## Eis vir Enkelbedragongeskiktheidsvoordeel en/of maandelikse ongeskiktheidsinkomste-voordeel

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

#### 1 Inhoud / Contents

Die volgende vorms moet voltooi word met die indiening van 'n eis vir 'n ongeskiktheidsvoordeel.  
The following forms must be completed for the submission of a claim for a disability benefit.

- **Verklaring deur fonds/skema** – *Moet deur die werkgewer voltooi word.*
  - **Declaration by fund/scheme** - *To be completed by employer.*
- **Verklaring deur versekerde** – *Moet deur die versekerde voltooi word.*
  - **Statement by insured** – *To be completed by the insured.*
- **Vertroulike mediese verslag** – *Die verslag moet deur die versekerde se behandelende spesialis opgestel word volgens aangehegte "Riglyne vir mediese verslag oor funksionele inkorting". (Sien bladsy 15).*
  - **Confidential medical report** - *Report to be compiled by insured's treating specialist according to the "Guidelines medical report on functional impairment" attached. (See page 16).*
- **Siekteverlofrekords** – *Voorsien afskrifte van siekteverlofrekords vir die afgelope 12 maande.*
- **Sick leave records** – *Provide copies of all sick leave records for the past 12 months.*

**Belangrik:** Indien daar bestaande spesialisverslae beskikbaar is moet afdrukke daarvan asseblief saam met die eisdokumente gestuur word.

**Important:** If there are any existing specialist reports available please forward copies with the claim documents.

#### 2 Algemeen / General

- Die versekerde moet die aanvanklike medies en ander dokumente ter staving van sy/haar ongeskiktheid betaal. Dit is die versekerde se verantwoordelikheid om sy ongeskiktheid te bewys in terme van die kontrakbepalings.
  - The insured has the initial responsibility of providing medical and other documentary evidence of disability at his/her own cost. It is the insured's responsibility to prove that he/she is disabled in terms of the policy provisions.
- Die versekerde is verplig om enige medies of ander inligting wat Sanlam redelikerwys nodig mag ag, te lewer.
  - The insured is obliged to submit whatever medical or other information Sanlam may reasonably require.
- Die versekerde moet ook chirurgie of enige ander mediese behandeling wat redelikerwys van hom/haar verwag kan word, ondergaan.
  - The insured should undergo surgery or any other medical treatment which can reasonably be expected from him/her to undergo.

#### **Die werkgewer moet asseblief die volledig voltooide vorms pos, faks of e-pos aan:**

Sanlam Groep Risiko Voordele: Ongeskiktheidseise (7709)  
Posbus 1  
Sanlamhof  
Bellville  
7532

Faksnommer (021)947-3207  
E-pos adres Disabilityclaimbenefits.EB@sanlam.co.za

#### **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

## Verklaring deur fonds/skema Declaration by fund/scheme

### A. Besonderhede van fonds/skema Particulars of fund/scheme

Naam van fonds/skema \_\_\_\_\_ Kode \_\_\_\_\_  
Name of fund/scheme \_\_\_\_\_ Code \_\_\_\_\_

Naam van deelnemende tak/werkgewer \_\_\_\_\_  
Name of branch/participating employer \_\_\_\_\_

E-posadres \_\_\_\_\_  
E-mail address \_\_\_\_\_

Telefoonnommer \_\_\_\_\_  
Telephone number ( ) \_\_\_\_\_

### B. Persoonlike besonderhede van versekerde Personal details of the insured

Volle voorname en van \_\_\_\_\_  
Full names and surname \_\_\_\_\_

Geboortedatum \_\_\_\_\_ (dd/mm/eejj) \_\_\_\_\_ Geslag: Manlik \_\_\_\_\_ Vroulik \_\_\_\_\_  
Date of birth \_\_\_\_\_ (dd/mm/ccyy) \_\_\_\_\_ Gender: Male  Female

Huwelikstaat: Enkel  Getroud  Geskei  Woon saam  Weduwee/Wewenaar   
Marital status Single  Married  Divorced  Co-habiting  Widowed

Identiteitsnommer \_\_\_\_\_  
Identity number \_\_\_\_\_

### Besonderhede van lidmaatskap Particulars of membership

Lidmaatskapnr. \_\_\_\_\_ Betaalstaatnr. (Indien enige) \_\_\_\_\_  
Membership no. \_\_\_\_\_ Pay-sheet no. (if any) \_\_\_\_\_

Datum van diensaanvaarding \_\_\_\_\_ Datum van vaste aanstelling \_\_\_\_\_  
Date of entering service \_\_\_\_\_ Date of permanent appointment \_\_\_\_\_

Aanvangsdatum van lidmaatskap \_\_\_\_\_  
Date of commencement of membership \_\_\_\_\_

Indien skema minder as een jaar deur Sanlam onderskryf is, voltooi die volgende:  
If the scheme has been underwritten by Sanlam less than one year, please complete the following:

Tipe voordeel en bedrag dekking wat versekerde geniet het by vorige versekeraar.  
Type of benefit and cover the insured enjoyed at previous insurer.

Tipe voordeel \_\_\_\_\_ Bedrag dekking \_\_\_\_\_  
Type of benefit \_\_\_\_\_ Amount cover R \_\_\_\_\_

Sedert watter datum het versekerde dekking geniet by vorige versekeraar?  
Provide the date from when the insured received cover at previous insurer? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Jaarlikse pensioengewende besoldiging van versekerde vir die afgelope 24 maande:  
Annual pensionable remuneration of insured for the past 24 months:

Datum salaris toegestaan Date salary received	Jaarlikse salaris (R) Annual salary (R)

**Besonderhede van lidmaatskap (vervolg)****Particulars of membership (continue)**

Vesekerde bedrag ten opsigte van ongeskiktheid

Sum assured in respect of disability

R \_\_\_\_\_

Datum van laaste aftrekking van lidbydraes

Date of last deduction of insured's contribution

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

(dd/mm/eejj)

(dd/mm/ccyy)

Werkgewerbydraes ten opsigte van die versekerde is/word betaal tot

Employer's contributions in respect of the insured was paid/will be paid up to

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Besonderhede van versekerde se beroep en alternatiewe beroepe****Particulars of insured's occupation and alternative occupations****Nota:** Hierdie gedeelte moet in ooreenstemming met die versekerde se onmiddellike hoof, toesighouer of deur enige iemand anders wat van die omstandighede kennis dra, ingevul word.**Note:** This section must be completed in consultation with the insured's immediate superior, overseer or by any other person who is conversant with the circumstances.

Beroep voor ongeskiktheid

Occupation before disablement \_\_\_\_\_

Naam van toesighouer

Name of supervisor \_\_\_\_\_

Telefoonnommer van toesighouer

Telephone number of supervisor

(\_\_\_\_) \_\_\_\_\_

Naam van kontakpersoon by Menslike Hulpbronne-afdeling

Name of contact person at Human Resources Department \_\_\_\_\_

Telefoonnommer van kontakpersoon

Telephone number of contact person

(\_\_\_\_) \_\_\_\_\_

Laaste datum waarop hy/sy gewerk het

Last date of performing his/her duties

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

(dd/mm/eejj)

(dd/mm/ccyy)

Het hy/sy enige ander werk na bogenoemde datum gedoen?

Did he/she do other work thereafter?

Ja

Yes 

Nee

No 

Indien 'Ja', verstrek die volgende besonderhede:

If 'Yes', provide the following particulars:

In watter kapasiteit?

In which capacity? \_\_\_\_\_

Werksbeskrywing

Description of work \_\_\_\_\_

Vanaf watter datum?

From which date? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Tot watter datum?

Until which date? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- Was die versekerde afwesig gedurende die 12 maande onmiddellik voor ongeskiktheid?

Was insured absent from service in the 12 months immediately before disability?

Ja

Yes 

Nee

No 

Indien 'Ja', verstrek die volledige besonderhede:

If 'Yes', provide the full particulars:

Vanaf datum / From date	Tot datum / To date	Redes (sieketoestand) / Reasons (disease)

- Opvoedkundige kwalifikasies van versekerde.

Educational qualification of insured. \_\_\_\_\_

- Opvoedkundige kwalifikasies/opleiding/ondervinding vereis vir beroep voor ongeskiktheid.

Educational qualifications/training/experience required for occupation before disability. \_\_\_\_\_

**Besonderhede van versekerde se beroep en alternatiewe beroepe** (vervolg)  
**Particulars of insured's occupation and alternative occupations** (continue)

Is die versekerde vir 'n pos elders in die onderneming oorweeg? Ja Nee  
Was the insured considered for any other position in the organisation? Yes  No

Indien "Ja" beantwoord asseblief die volgende vrae.  
If 'Yes', please answer the following questions.

In watter hoedanigheid was dit?  
In what capacity? \_\_\_\_\_

Is die pos in status Hoër Gelyk Laer as vorige posisie  
Is the position Higher  Equal  Lower  to the previous position

Indien u antwoord in die vorige paragraaf "Laer" is, verstrek asseblief redes waarom 'n laer graad pos die versekerde aangebied is (bv. as gevolg van graad van ongeskiktheid nie gekwalifiseer vir hoër graad pos nie, geen hoër graad pos was beskikbaar, ens.).

If you answered "lower" in the previous paragraph, please give reasons why the insured was offered a lower grade position (e.g. as a result of the degree of disability he/she no longer qualified for higher grade post, no higher grade post was available, etc.).

Gemiddelde vergoeding per maand in hierdie pos:

Average remuneration per month in this position: \_\_\_\_\_

Het die versekerde die pos aanvaar?

Did the insured accept the position? \_\_\_\_\_

Indien nie, verstrek asseblief redes:

If not, please provide reasons: \_\_\_\_\_

Indien versekerde nie elders oorweeg/geplaas kan word nie, verstrek asseblief redes:

If insured could not be consider/placed elsewhere, please give reasons: \_\_\_\_\_

**Versekerde se beroepsbesonderhede**  
**Details regarding the insured's occupation**

Pos deur die versekerde bekleed.  
Position held by insured. \_\_\_\_\_

Wanneer laas was die versekerde bevoeg om sy beroep te beoefen? (dd/mm/eejj)  
When was the insured last able to do his own occupation? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ dd/mm/ccyy

Dui aan in watter werkskategorie die versekerde val. (Merk asseblief die toepaslike opsie met 'n X)  
What was the insured's job category? (Please mark the most applicable with an X)

- |   |  |
|---|--|
| <input type="checkbox"/> Bestuurder<br>Managerial                     | <input type="checkbox"/> Masjien operateur (bv. bestuur van of gebruik van masjien om taak te verrig)<br>Machine operator (eg. driving or using a machine to perform the task) |
| <input type="checkbox"/> Toesighouer<br>Supervisor                    | <input type="checkbox"/> Ligte hande arbeid (bv. fisiese verpakking en sortering)<br>Light manual labour (eg. physically packing or sorting)                                   |
| <input type="checkbox"/> Klerklik<br>Clerical                         | <input type="checkbox"/> Swaar hande arbeid (bv. fisiese grawe of op laai)<br>Heavy manual labour (eg. physically digging or loading)  |
| <input type="checkbox"/> Ander (spesifiseer)<br>Other (specify) _____ |  |

**Bestuur van voertuie**  
**Driving a vehicle(s)**

Tipe voertuig of voertuie:  
Type of vehicle or vehicles: \_\_\_\_\_

Tipe terrein waarop voertuig bestuur word:  
Type of terrain where vehicle is driven: \_\_\_\_\_

Skatting van afstand, in kilometers, wat oor 'n spesifieke periode bv. per dag/per week/per maand, afgelê word.  
Estimate distance, in kilometres, covered over a specific period, e.g. per day/per week/per month.

**Versekerde se beroepsbesonderhede (vervolg)**

Details regarding the insured's occupation (continue)

Dui asseblief die versekerde se hoof pligte aan:

Please list the insured's main duties:

Plig / Duty	Gewig / Weight (%)	Vermoë om 'n taak te verrig / Ability to perform		
		Bekwaam / Able	Gedeeltelik bekwaam / Partially able	Onbekwaam / Unable
	100%			

(Vul asseblief die nodige inligting in en merk die toepaslike opsie met 'n X)

(Complete the necessary details and mark the applicable option with an X)

Werkvereiste Job demands	%	Frekwensie per dag Frequency per day	%	Maksimum gewig gemanipuleerd / Maximum weight manipulated	Gereeld Frequent	Per geleentheid Occasional
Fisies / Physical		Stap / Walking		4.5kg		
		Staande / Standing		9kg		
		Sittende / Sitting		22kg		
		Klim / Climbing		45kg		
		Gebukkend / Stooping		+45kg		
			100%			

Werkvereiste Job demands	%	Frekwensie per dag Frequency per day	%	Maksimum gewig gemanipuleerd / Maximum weight manipulated	Gereeld Frequent	Per geleentheid Occasional
Toesighoudend / Supervisory		Stap / Walking		4.5kg		
		Staande / Standing		9kg		
		Sittende / Sitting		22kg		
				45kg		
				+45kg		
			100%			

Werkvereiste Job demands	%	Frekwensie per dag Frequency per day	%	Take / Tasks	Gereeld Frequent	Per geleentheid Occasional
Administratief / Administrative		Stap / Walking		Liassering / Filing		
		Staande / Standing		Tikwerk / Typing		
		Sittende / Sitting		Telefoon hantering / Telephone use		
				Vergaderings / Meetings		
	100%		100%			

**Versekerde se beroepsbesonderhede (vervolg)**  
**Details regarding the insured's occupation (continue)**

Beskryf die minimum vermoë wat 'n gesonde individu moet hê om die werk te verrig.  
 Please describe the minimum abilities that a healthy individual requires to do this job.

	Vlak van vermoë / Level of ability		
	Ongeskool / Unskilled	Geskool / Skilled	Professioneel / Professional
Geletterd / Literacy			
Syferkennis / Numeracy			
Geheue / Memory			
Probleem oplossing/redenering / Problem solving/Reasoning			
Gespesialiseerde kennis / Specialised knowledge			

Beskryf die minimum kommunikasie vaardighede wat 'n gesonde individu moet hê om die werk te verrig.  
 Please describe the minimum communication skills that a healthy individual requires to do this job.

	Vlak van vermoë / Level of ability		
	Ongeskool / Unskilled	Geskool / Skilled	Professioneel / Professional
Geletterd / Literacy			
Syferkennis / Numeracy			
Geheue / Memory			
Probleem oplossing/ redenering / Problem solving/Reasoning			
Gespesialiseerde kennis / Specialised knowledge			

Hoe gereeld werk die versekerde in die volgende omstandighede?  
 How often does the insured work in the following conditions?

Werkomstandighede / Work conditions	Hoe gereeld? / How often?	Werkomstandighede / Work conditions	Hoe gereeld? / How often?
Binnenshuis / Indoors		Stof / Dust	
Buite / Outdoors		Vibrasie / Vibration	
Hoogtes / Heights		Geraas / Noise	
Ondergrond / Underground		Walms / Fumes	
Nat areas / Wet areas		Uitermatige hitte / Extreme heat	
Koue / Cold storage		Stap op ongelyke oppervlakte / Walking on uneven surfaces	
Klim (trappe/leer) / Climbing (stairs/ladder)		Werk met masjinerie / Operate machinery	
Bestuur: Tipe voertuig / Driving: Type of vehicle		Geskatte afstand afgelê per dag/week/maand / Estimate distance covered per day/week/month	

### C. Algemeen

#### General

- Ontvang die versekerde, of verwag hy/sy om enige voordeel te ontvang, van watter aard ookal, as gevolg van sy/haar ongeskiktheid? (Dit sluit in ontvangstes van die Kommissaris, Pensioenfonds, staatsfonds of enige ander bron.)

Does the insured receive, or expect to receive, any benefits of whatever nature, as a result of his or her disability? (This income includes income from the Commissioner, pension fund, government fund or any other source.)

Ja  Nee   
Yes  No

Indien 'Ja', verstrek asseblief die volgende besonderhede:

If 'Yes', please provide the following details:

#### Gereelde bedrae / Regular amounts

Bron van voordeel Source of benefit	Bedrag Amount	Aanvangsdatum van betaling Commencement date of payment	Stakingsdatum Cessation date

- Ontvang die versekerde sedert die datum van ongeskiktheid of verminderde besoldiging of geen besoldiging?

Has the insured received either reduced remuneration or no remuneration since disablement?

Ja  Nee   
Yes  No

Indien 'Ja', verskaf besonderhede asseblief.

If 'Yes', please provide details. \_\_\_\_\_

- Laaste datum waarop versekerde volle besoldiging ontvang het.

Last date on which the insured received full remuneration. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (dd/mm/eejj)

(dd/mm/eejj)

(dd/mm/ccyy)

**Belangrik:** Heg asseblief 'n afskrif van die versekerde se identiteitsdokument aan.

**Important:** Please attach a copy of the insured's identity document.

Ons die ondergetekendes, verklaar namens die fonds/skema dat die inligting hierbo verstrek volledig en korrek is.

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

#### Onderteken namens die fonds/skema

#### Signed on behalf of the fund/scheme

Voorletters en van

Initials and surname \_\_\_\_\_

Hoedanigheid

Designation \_\_\_\_\_

Handtekening

Signature \_\_\_\_\_

Plek

Place \_\_\_\_\_

Datum

Date \_\_\_\_\_

(dd/mm/eejj)

(dd/mm/ccyy)

## D Mediese Fonds Bydraekwytskeldingsvoordeel / Medical Aid Premium Waiver benefit

Die volgende inligting moet verskaf word as 'n eis vir die Mediese Fonds Bydraekwytskeldingsvoordeel oorweeg moet word tesame met die ongeskiktheid van die versekerde.

The following information must be provided if a claim for the Medical Aid Premium Waiver Benefit must be considered with the disability of the insured.

Naam van versekerde se Mediese Fonds

Name of insured's Medical Aid Scheme \_\_\_\_\_

Besonderhede van afhanklikes Particulars of dependants	Naam en van Name and surname	Geboortedatum Date of birth	Bedrag van Mediese Fonds premie * Amount of Medical Aid premium *
Hooflid / Principle member			
Gade / Spouse			
Kind / Child (1)			
Kind / Child (2)			
Kind / Child (3)			
Kind / Child (4)			

\* insluitend die premie vir spaarrekening en ongeboore kind indien swangerskap in die tweede of derde trimester

\* including the premium for savings account and unborn child if pregnancy is in second or third trimester

- Is die versekerde 'n lid van die Vitality program? Ja  Nee
- Are the insured a member of the Vitality programme? Yes  No

Indien "Ja", bevestig die premie

If "Yes", state the premium R \_\_\_\_\_

- Het die lid enige Gaping dekking? Ja  Nee
- Does the insured have GAP cover? Yes  No

Indien "Ja", bevestig die premie

If "Yes", state the premium R \_\_\_\_\_

- Is die bogenoemde voordele ingesluit by die Mediese Fonds premie? Ja  Nee
- Are the above included in the Medical Aid Premium? Yes  No

Volgens die polis, is die betalings vir die Mediese Fonds Bydraekwytskeldingsvoordeel betaalbaar aan die Werkgewer  
According to the policy, payments for the Medical Aid Premium Waiver Benefit are payable to the Employer

Naam van Werkgewer

Name of employer \_\_\_\_\_

Naam van bank

Name of bank \_\_\_\_\_

Takkode

Branch code \_\_\_\_\_

Rekeningnommer van werkgewer

Account number of employer \_\_\_\_\_

**Belangrik:** Sanlam moet asseblief in kennis gestel word indien enige van die voorafgaande inligting verander wat betrekking het op die Mediese Fonds Bydraekwytskeldingsvoordeel

**Important:** Please inform Sanlam if any of the above-mentioned information should change with regards to the Medical Aid Premium Waiver Benefits



## Verklaring / Declaration

Ons, die ondergetekendes, verklaar hiermee names die fonds/skema, dat die inligting hierbo verskaf volledig en korrek is.  
We, the undersigned, declare on behalf of the fund/scheme, that the information provided above is complete and correct.

### Geteken namens die fonds/skema / Signed on behalf of the fund/scheme

Voorletters en van Initials and surname	_____	Voorletters en van Initials and surname	_____
Hoedanigheid Designation	_____	Hoedanigheid Designation	_____
Handtekening Signature	_____	Handtekening Signature	_____
Plek Place	_____	Datum Date	_____ / _____ / _____ (dd/mm/eejj) (dd/mm/ccyy)

# Ongeskiktheidseis: Verklaring deur versekerde

## Disability Claim: Declaration by Insured

Naam van fonds/skema  
Name of fund/scheme \_\_\_\_\_

Naam van versekerde  
Name of insured \_\_\_\_\_

Geboortedatum \_\_\_\_\_ Identiteitsnommer \_\_\_\_\_  
Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Identity number \_\_\_\_\_

Lidmaatskapnommer  
Membership number \_\_\_\_\_

Telefoonnommer \_\_\_\_\_ Selfoonnommer \_\_\_\_\_  
Telephone number (\_\_\_\_) \_\_\_\_\_ Cell phone number (\_\_\_\_) \_\_\_\_\_

E-posadres  
E-mail address \_\_\_\_\_

### 1 Beroepsgeskiedenis Occupational history

- Verskaf asseblief 'n volledige uiteensetting van u loopbaan geskiedenis met inbegrip van u huidige beroep. Die presiese datum(s) waarop diens aanvaar en beëindig is, word verlang:  
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:

Naam en adres van werkgever Name and address of employer	Tydperk indiens / Vanaf / From	Period in service Tot / To	Aard van werk Nature of work

- Beskryf asseblief die kernfunksies van u beroep onmiddellik voor ongeskiktheid.  
Please describe the most important functions of your occupation directly before disablement.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Was u in staat om u eie beroep of enige ander beroep of funksie te verrig sedert u oorspronklik ongeskik geraak het?  
Have you been able to perform your own occupation or any other occupation or function since you first became disabled? Ja  Nee   
Yes  No

Indien 'Ja', verskaf asseblief inligting:  
If 'Yes', please give details:

Datum / Date	Titel van beroep / Job title	Vergoeding / Remuneration

- Op watter datum het u laas aktief u gereelde beroep beoefen? \_\_\_\_\_ (dd/mm/eejj)  
On what date did you last actively practise your occupation? \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (dd/mm/ccyy)
- Opvoedkundige kwalifikasies: Hoogste skool kwalifikasies \_\_\_\_\_  
Educational qualifications: Highest school qualification \_\_\_\_\_  
Ander opleiding/kwalifikasies \_\_\_\_\_  
Other training/qualifications \_\_\_\_\_

**Beroepsgeskiedenis (vervolg)**  
**Occupational history (continue)**

- Op grond van u ondervinding en opleiding, watter ander beroepe is u van mening kan u beoefen?  
 Based on your experience and training, what other occupations can you perform?

---



---

- Wanneer verwag u om in staat te wees om u werk te hervat?  
 When do you expect to be able to resume work?

Voltyds \_\_\_\_\_ Deeltyds \_\_\_\_\_ (dd/mm/eejj)  
 Full time \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Part time \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (dd/mm/ccyy)

**2 Aard van ongeskiktheid en mediese sorg**  
**Nature of disability and medical care**

- Naam en adres van u gereelde huisdokter. \_\_\_\_\_ Name \_\_\_\_\_  
 Name and address of your regular family doctor. \_\_\_\_\_ Name \_\_\_\_\_  
 Adres \_\_\_\_\_  
 Address \_\_\_\_\_

- Sedert watter datum is hy/sy u huisdokter? \_\_\_\_\_ (dd/mm/eejj)  
 Since what date has he/she been your family doctor? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (dd/mm/ccyy)

- Datum van die laaste konsultasie. \_\_\_\_\_ (dd/mm/eejj)  
 Date of last consultation. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (dd/mm/ccyy)

Naam van vorige huisdokter? \_\_\_\_\_  
 Name of previous family doctor? \_\_\_\_\_

- Watter siekte, besering of afwyking maak u ongeskik om te werk?  
 Which illness, injury or impairment causes your inability to work?

---



---

- Beskryf asseblief die simptome wat u ondervind en hoe dit u vermoë om te werk beperk.  
 Please describe the symptoms that you are experiencing and how they influence your ability to work.

---



---

- Sedert watter datum ondervind u die simptome? \_\_\_\_\_ (dd/mm/eejj)  
 Since what date did you experience the symptoms? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (dd/mm/ccyy)

- Op watter datum het u vir die eerste keer 'n geneesheer hiervoor geraadpleeg?  
 On what date did you see a doctor about this for the first time? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Wat is die naam van die geneesheer?  
 What was the name of this doctor? \_\_\_\_\_

- Verskaf asseblief besonderhede van alle dokters, spesialiste en hospitale wat u geraadpleeg het.  
 Please provide the names of all doctors, specialists and hospitals that you have consulted in this regard.

Datum/ Date		Naam van hospitaal of dokter / Name of hospital or doctor	Adres / Address	Telefoonnummer / Telephone number
Vanaf / From	Tot / To			

**Aard van ongeskiktheid en mediese sorg (vervolg)**

**Nature of disability and medical care (continue)**

- Hoe bring u tans u dae deur? (Bv. stokperdjies, ens.)  
How do you presently spend your days? (Hobbies, etc.)

---

---

- Watter aktiwiteite (uitsluitende werkstake) wat u voor u siekte/ongeluk uitgevoer het kan u tans nie uitvoer of ondervind u probleme mee?  
Which activities (excluding work tasks) can you not perform or do you experience problems with at present, as a result of your sickness/accident?

---

---

- Indien u enigsins belemmer is in die behartiging van u persoonlike belange of in die alledaagse versorging van u persoon, meld asseblief in watter opsig.  
If you are at all handicapped in looking after your personal interests or caring for your person, please state in what respect.

---

---

- Indien u ongeskiktheid deur 'n ongeluk veroorsaak is, verstrek asseblief die volgende inligting:  
If your disability was caused by an accident, please give the following information:

- Omstandighede wat tot die ongeluk aanleiding gegee het.  
Circumstances causing the accident.

---

---

- As 'n formele ondersoek gehou is, meld asseblief deur wie en wat die uitslag daarvan was.  
If a formal enquiry was conducted, please state by whom and what the result was.

---

---

- Datum van ongeluk \_\_\_\_\_ (dd/mm/eejj)  
Date of accident \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (dd/mm/ccyy)

**3 Inkomste  
Income**

- Het u as gevolg van of tydens u ongeskiktheid enige voordeel, salaris, pensioen of vergoeding van watter aard ook al, ontvang of verwag u om te ontvang? (Insluitend ontvangstes van enige werkgewer, vennoot, versekeringsmaatskappy, 'n pensioen- of uitredings- annuïteitsfonds, enige staatsfonds of van enige ander bron.)

Are you receiving or do you expect to receive, as a result of or during your disability, any benefit, salary, pension or compensation of whatever nature? (Including income from any employer, partner, assurance company, a pension or retirement annuity fund, any governmental fund or any other source.)

Ja  Nee   
Yes  No

- Indien "Ja" verstrek asseblief die volgende besonderhede:  
If 'Yes', please give the following details:

**Gereelde bedrae (Lyfrentes en jaargelde ingesluit.)**  
**Regular amounts (Including Life annuities.)**

Bron van voordeel / Source of benefit	Bedrag / Amount (R)	Aanvangsdatum van betaling / Commencement date of payment	Datum waarop dit gestaak word / Date of cessation

**Inkomste** (vervolg)  
**Income** (continue)

**Ongeskiktheidsbedrae ingesluit by gewone versekering by enige ander maatskappye** (Ongeag of eis reeds ingedien is.)  
**Disability amounts included in ordinary assurance at any other companies** (Regardless of whether claim has been submitted already.)

Naam van maatskappy / Name of company	Bedrag / Amount (R)	Datum van betaling / Date of payment

**4 Betaling van voordele**  
**Payment of benefits**

**Kontakbesonderhede / Contact details**

Posadres  
Postal address \_\_\_\_\_

Woonadres  
Residential address \_\_\_\_\_

Telefoonnommer  
Telephone number ( \_\_\_\_\_ ) \_\_\_\_\_

**Bankbesonderhede / Bank details**

Naam van bank \_\_\_\_\_ Tak \_\_\_\_\_  
Name of bank \_\_\_\_\_ Branch \_\_\_\_\_

Tipe rekening: Lopend  Spaar  Transmissie   
Type of account: Current  Savings  Transmission

Rekeningnommer  
Account number \_\_\_\_\_

**Belangrik:**

**Important:**

Indien voordele in u bankrekening betaal moet word, voorsien ons asseblief van 'n gekanselleerde tjek of 'n gesertifiseerde inlegstrokie in geval van 'n spaarrekening.  
If the benefits are to be paid into your bank account, please provide us with a cancelled cheque or a certified deposit slip in the case of a savings account.

**Belastingbesonderhede / Tax particulars**

Inkomstebelastingverwysingsnommer  
Income tax reference number \_\_\_\_\_

Inkomstekantoor waar vorige opgawe ingedien is  
Income tax office to which last return was rendered \_\_\_\_\_

**5 Algemeen**  
**General**

Verstrek asseblief enige ander inligting wat na u mening die eis kan beïnvloed.  
Please give any other information which, in your opinion, may influence the claim.

---

---

---

---

---

---

---

---

---

---

Premiebetaling moet voortgaan totdat 'n eis, indien enige, erken is.  
Premium payments must continue until claim, if any, is admitted.

## 6 Verklaring Declaration

Ek verklaar dat ek die persoon is wat hierbo beskrywe word en dat die antwoorde en die opgawes deur my hierbo verstrek in elke opsig waar en korrek is.

Terwyl ek aanvaar dat ek my reg op privaatheid daardeur inkort, maar om die beoordeling van die risikos en die oorweging van enige eis om voordele makliker te maak, ingevolge 'n polis verband hou met hierdie of enige ander aansoek om versekering deur my, of aangaande my as versekerde, magtig ek Sanlam onherroeplik om:

- Enige inligting wat Sanlam nodig ag van enige persoon te bekom - wat ek hiermee magtig en versoek om die inligting aan Sanlam te gee.
- Daardie inligting en enige inligting in hierdie aansoek of enige verwante polis of ander dokument vervat met ander versekeraars te deel - hetsy regstreeks, hetsy deur 'n databasis wat deur of vir versekeraars as 'n groep bedryf word, te enigertyd (selfs na my dood) en in sodanige gedetailleerde, of verkorte of gekodifiseerde vorm waarop Sanlam of die operateurs van die databasis van tyd tot tyd besluit.

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.

Handtekening

Signature \_\_\_\_\_

Getuie

Witness \_\_\_\_\_

Datum

Date \_\_\_\_\_ (dd/mm/eejj)  
(dd/mm/ccyy)

Plek

Place \_\_\_\_\_

## Verslag deur die behandelende spesialis

**Belangrik: Hierdie verslag moet deur 'n spesialis opgestel word en nie deur 'n algemene praktisyn nie.**

Geagte dokter

Voordat u die ondersoek doen, moet u die identiteit van die versekerde met behulp van 'n fotografiese identiteitsbewys vasstel. Dui asseblief aan op u ondersoekbevindings watter soort identiteitsbewys aangebied is.

Wanneer 'n ongeskiktheidseis evalueer word, moet ons onderskei tussen die twee hoofbeginsels van **funksionele inkorting** en **ongeskiktheid**. Die evaluering van **funksionele inkorting** behels uit 'n praktiese oogpunt dat 'n diagnose gemaak en daarna op mediese grond bepaal word watter funksie die persoon nog kan verrig en watter nie. Aan die ander kant is **ongeskiktheid** 'n regsproses waar die omvang van die persoon se **funksionele inkorting** beoordeel word aan die hand van sy/haar posbeskrywing, die bewoording in die polis en persoonlike faktore soos opleiding, ondervinding, ensovoorts.

Om ons te help om 'n regverdigte besluit te neem, moet ons voorsien word van 'n verslag betreffende **funksionele inkorting** van hierdie persoon. Die besluit oor **ongeskiktheid** sal deur Sanlam Lewensversekering Bpk ("Sanlam Beperk") geneem word.

Voorsien ons asseblief van 'n verslag volgens die riglyne soos uiteengesit in die *Riglyne vir mediese verslag oor funksionele inkorting* hieronder, nadat die persoon ondersoek is.

Die versekerde is verantwoordelik vir die koste verbonde aan hierdie konsultasie en mediese verslag. Indien u dit nodig ag om verdere ondersoeke te doen, sal dit ook vir die versekerde se rekening wees.

### Riglyne vir mediese verslag oor funksionele inkorting

Gebruik die volgende asseblief slegs as riglyn om u verslag op te stel.

- Diagnose (*DSM IV vir psigiatriese toestande*)
- Datum van aanvang en verloop van siekte
- Erns: *Aanleidende faktore, sekondêre voordeel*
- Huidige kliniese bevindings. *Beskryf volledig.*
- Behandeling
  - Behandelingsmodaliteite
  - Tipe medikasie en dosering
  - Tydsduur en behandeling
  - Terapeutiese prosedure
  - Rehabilitasie
  - Hospitalisasie
- Reaksie op behandeling
- Komplikasies wat permanent is.
- Spesiale ondersoeke (bv. EKG, X-strale, skanderings)
- Prognose met optimale behandeling
- Invloed op lewenstyl, aktiwiteite van daaglikse lewe en werksaktiwiteite
- Spesiale vereistes
  - Kardiovaskulêr: NYHA klassifikasie, oefeningskapasiteit, inspannings EKG, uitwerpfraksie, ander.
  - Respiratories: dispnee-gradering(ATS), oefeningskapasiteit,(METS of VO2 max.) vitalogram voor en na -inhalasie (3 pogings), borskas X-strale, enkel inasemingdiffusietoets (Dco) in gevalle van interstisiële longsiekte.
  - Ortopedies: X-strale met stres opnames, MRI of CAT skanderings, ander (bv. senuwee-geleidingstoetse).
  - Psigiatry: sosiale funksionering, konsentrasie, psigometriese toetse in gevalle van kognitiewe inkorting.

## Report by the treating specialist

**Important: This report must be compiled by a specialist and not a general practitioner.**

Dear doctor

Before you perform the examination, please determine the insured'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 assessment of a disability claim is based on the 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 policy 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 the disability will be made by Sanlam Life Insurance Ltd ("Sanlam Life").

Please supply us with a report in accordance with the guidelines set out in the *Guidelines medical report on functional impairment* underneath after you have examined the insured.

The insured is responsible for the costs relating to this consultation and medical report. Should you require additional investigations, these will also be for the account of the insured.

### Guidelines medical report on functional impairment

Please use the following only as a guideline to compile your report.

- 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