Sanlam

Group Risk: Disability Claims & Assessment process

We acknowledge the difficult time our clients experience in the unfortunate event of claiming for a deceased love one, or when experiencing an illness or injury.

As we realise that, having trust in the insurer to pay claims, Sanlam endeavours to always act in the best interests of clients by committing to paying valid claims.

How to claim for a disability benefit?

Notification

It is important that Sanlam is informed of a potential claim as soon as possible.

As it can take some time to gather all the information required for a formal claim submission, Sanlam must be notified of any potential claims (even if the claim documentation is not received as yet) **within 6 months** from the date of event (e.g. disability):

- *Notification of Potential Disability Claim*-form – this must please be completed by the employer as soon as they become aware of a potential disability claim;
- The period is calculated from the first day that the employee is unable to perform his occupational duties; and
- This notification should include the member's details i.e. name, surname, date of birth and the last date of active service.

When to submit a claim

A claim should be submitted when an employee, due to illness or injury, is:

- Unlikely to return to work;
- Is on sick leave for longer than 14 working days;
- Has returned to work but is unable to perform the duties of their own job and is unable to perform any other job;
- Shows a decrease in productivity due to a medical reason; or
- Has a medical or psychiatric incident and may require hospitalisation, rehabilitation or to be off work for an extended period of time.

Once Sanlam has been notified, we can advise the employer if any specific medical assessments or tests are needed, or if a specific medical practitioner needs to be consulted, or the claims forms to be completed. This can prevent unnecessary delays.

Please note – Any intervention programme should start as soon as possible after an injury or diagnosis.

To increase an employee's chances of an efficient recovery, and to prevent them from being without an income if they are no longer able to return to work, proactive claims management can be beneficial to both the employer and employee.

Service delivery

On receipt of the full claims package, the standard turn-around-time within which the assessment will be finalised is as follows:

Kindly please submit the claim notification and supporting claim documentation to: DisabilityClaimBenefits.EB@sanlam.co.za

(Includings terminal illness and critical illness insurance claims)

- Assessment of initial disability claims — within 10 working days

  Please note that the assessment of the claim and supporting documents may take longer for certain cases, but we try our best to finalise and arrange for payment as soon as possible.)

- Assessment of review disability claims — within 10 working days

Please note – No documents should be forwarded to a personal inbox, or to that of any other individuals. This procedure ensures that the Administration & Claims Departments keep proper track of every document received.

Payment of medical accounts

Kindly please submit medical accounts to: DisabilityClaimBenefits.EB@sanlam.co.za

- Payment of medical accounts — within 10 working days

Please note – The employee or employer is responsible for the cost of attaining all the initial medical evidence submitted in support of the claim. Sanlam will only cover the cost of further medical evidence specifically requested.

- Initial evidence: Employee / employer
- Further evidence: Sanlam Employee Benefits: Group Risk
- Appeal evidence: Employee

Process that follows the disability claim submission:

Step1

Employer receives notification of an employee not being able to work

(If an employee has been affected by injury or disease to the extent that they can't perform their own occupation or most of it, they should discuss it with management as soon as possible)

Step 2

Employer notifies Sanlam of the employee's inability to perform regular occupation

(Employee/employer must arrange for appointment with a suitable qualified doctor)

Please note – Notices received later than 6 (six) months of date of disability will not qualify for disability benefits

Step 3

Employer receives further medical notification that the employee is continuously and totally prevented from following the regular occupation *(i.e. the assessing doctor finds the condition as disabling)*.

Employer arranges for the following information to be sent/forwarded to Sanlam:

- Declaration by scheme
- Statement by insured
- Confidential medical report – compiled by treating specialist
- Sick leave records
- Copy of claimant's ID

Please note – All documents must be duly completed and signed

Cost of 1st medical is for the employee's own account

Step 4

Sanlam receives the claim pack, assesses the claim and notify the client of decisions made.

Request additional medical and/or other information	Claims is approved	Claim is repudiated
Sanlam sends a letter to the employer, via the intermediary (if applicable), requesting the additional information, necessary to finalise the claim assessment	Sanlam requests, via the intermediary (if applicable), the fund / employer's or employee's banking details from the employer, in order to arrange payment of the benefit	Sanlam sends a letter, via the intermediary (if applicable), informing the employer of the repudiation
Claim is on hold until additional information is received (*Please note* – It is the members responsibility to submit the additional information / medical reports)	Sanlam sends letter, addressed to the employer | employee, via the intermediary (if applicable), confirming benefit being paid (after the waiting period has elapsed), as well as proof of payment, if required	In the event that the employee is not satisfied with our decision, he/she may within 90 days provide us with written representation of his/ her dissatisfaction, together with medical reports in support thereof

Please note – The turn-round time for this process, should all the relevant information be submitted and the assessment finalised by the doctor (excluding any follow-up for additional information) is 10 working days

Formal claim submission *(step 3)*

Following the Notification of Potential Disability Claim-form, the following information is required as soon as the relevant information becomes available:

Disability claim (lump sum / monthly instalment):

- **Declaration by fund / scheme / employer** – to be completed by the employer (part of claim form).

  It is important to state the employee's last day able to perform all their duties because of the medical condition. Certain contractual elements are dependent on this date and in essence is the "date of disability".

- **Particulars of the insured's occupation i.e. Job Description/Job Profile of insured** – to be submitted by the employer.

  This detailed information is required by the claims consultant to assess the claim in terms of the policy's definitions of disability, and needs to show the main duties required of the employee; it should therefore be completed by the immediate supervisor together with the employee.

- **Payment of benefits** – to be completed by the employer (part of claim form – only complete sections applicable, i.e. Income Continuation disability benefit sections).

- **Declaration by insured / employee** – to be completed by claimant (part of claim form).

  Contact details of all medical practitioners consulted are required. The declaration must also be signed, giving Sanlam the authority to obtain medical evidence from other sources to assist with the assessment.

- **Confidential medical report** – Report to be compiled by insured's **treating specialist according to the guidelines attached** (see last page of claim form).

  The medical practitioner treating the employee should complete the confidential medical report. Copies of any specialist reports, test results and / or X-ray results should also be attached.

In addition:

- **Salary statement** – The employer must 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, Sanlam require the past 3 year's salary statements.)

  This serves as proof of membership as well as assist in calculating the payment of the disability benefit;

- **Sick and annual leave records** – the employer must provide copies of all sick and annual leave records for the past 12 months; and

- A clear certified copy of the employee's identity document is needed as proof of identity and as confirmation of age.

Important:

Copies of any other available medical reports or test results

Any other information (especially **existing specialist reports** and other medical information, but not older than 6 months) that will assist to determine the validity of the claim.

Terminal illness claim:

- **Declaration by fund / scheme / employer** – to be completed by the employer (part of claim form).
- **Payment of benefits** – to be completed by the employer (part of claim form).
- **Declaration by physician** – to be completed by the employee's **treating specialist** (part of claim form), i.e. of the diagnosis of a member's terminal illness confirming a member has less than 6 months to live.

Critical / Severe illness claim :

- **Declaration by fund / scheme / employer** – to be completed by the employer (part of claim form).
- **Statement by insured / employee** – to be completed by claimant (part of claim form).
- **Payment of benefits** – to be completed by the employer (part of claim form – only complete sections applicable, i.e. Income Continuation disability benefit sections).
- **Questionnaire to Doctor** – Form to be completed by the employee's **treating specialist**. In addition, the specialist also need to compile the report.

Important: Any other information (especially **existing specialist reports** and other medical information, but not older than 6 months) that will assist to determine the validity of the claim.

Please note – Incomplete or incorrect information may result in delays in the settling of the claim; kindly please ensure that the information given is complete, detailed and accurate to establish the facts of the case at an early stage.

Any misstatement could be used as a basis for the denial of a claim.

All information will be handled with confidentiality

Assessment *(step 4)*

Before assessing the extent of the employee's disability, the claims consultant must ensure that the claim fulfils certain contractual criteria.

The assessment process includes consultation with medical professionals and requesting further information where needed.

Complexity of claims

Each disability case is handled on its own merits, as each case differs in terms of employee profile, medical condition, prognosis, occupation, industry, availability of resources.

This makes most claims complex in nature. The complexity is brought about by subjective evidence and biased reports.

The most important aspect in the assessment of claims is to differentiate between *impairment* and *disability*.

- Impairment is the deterioration in functioning as a result of deterioration in an individual's health.

  Assessment involves a medical decision made by the examining physician, which is taken after a diagnosis has been confirmed and the medical condition has been optimally treated.

- On the other hand, disability involves a legal decision and reflects the inability of an individual to fulfil his personal, social or work liabilities fully as a result of the impairment.

  At Sanlam a panel of experts does this assessment.

Sanlam assesses the validity of the claim during the waiting period, after which payment will be made if the claim is admitted.

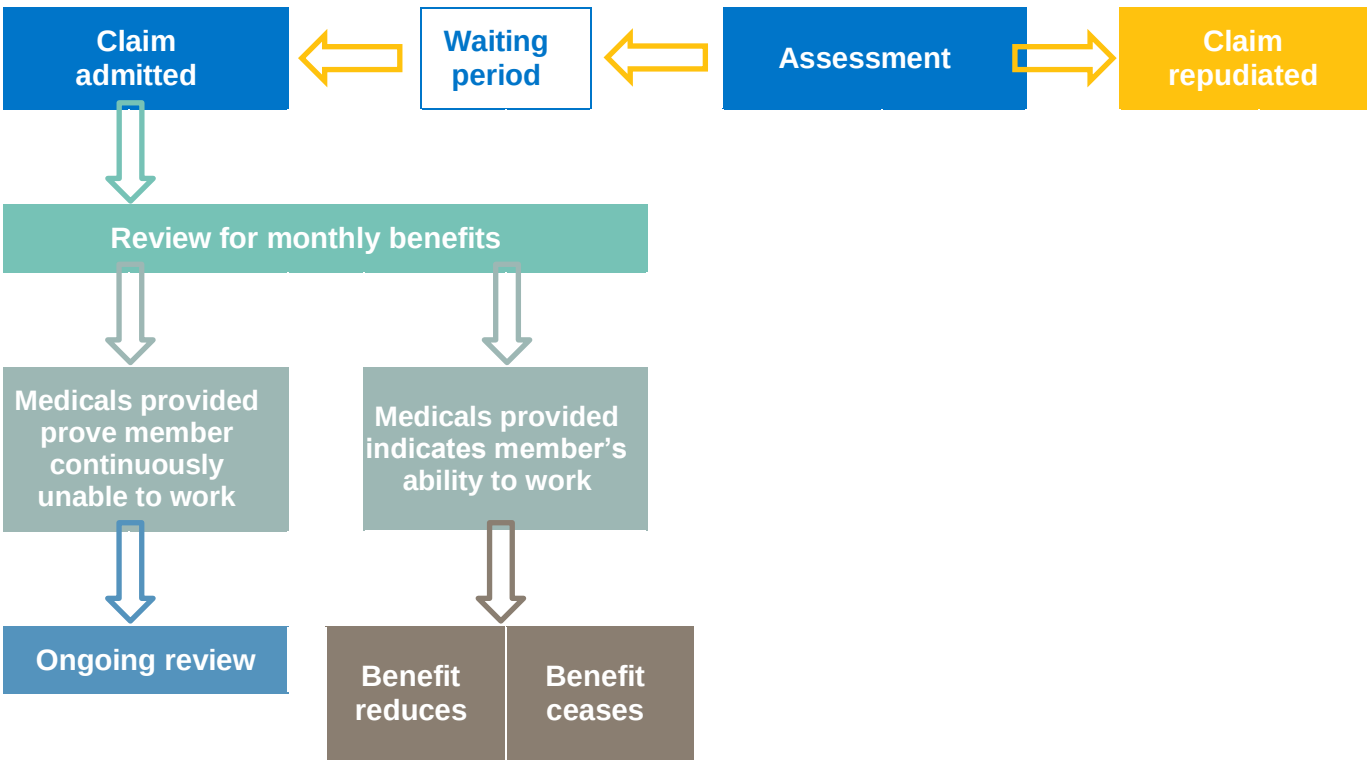
However, if the claim cannot be immediately admitted, a request for additional medical information may be made, in which case the claim will be temporarily suspended, until receipt of the requested information.

Very thorough process

Disability assessment at Sanlam is a very thorough process involving:

- Obtaining all relevant medical data on the history and course of the condition, the treatment supplied and the resultant functional impairment from the treating physician.

  We rely on HR to assist with the fully completed forms.
- Requesting additional evaluations by an independent medical examiner in diagnoses where subjective signs or symptoms are difficult to quantify.
- Obtaining information regarding the claimant's profile (i.e. Age, Qualifications, Experience and Previous occupations) to consider the possibility of re-deployment in suitable alternative occupation.
- An analysis of the physical and cognitive demands of the claimant's regular occupation and determine the effect of the functional impairment to such demands.
- Determining if the functional impairment to satisfy the condition of total or total and permanent disability as defined in the policy agreement.
- Impairment is assessed by medical doctors, qualified as specialists in disability assessment.
- Disability is assessed by full time claim assessors, assisted by legal consultants as well as occupational therapists.



Sanlam will notify the fund / employer of the outcome of the assessment.

Review of monthly disability benefits, after initial assessment

All claims are reviewed on a regular basis, depending on the specific claim and condition.

- In terms of the policy agreement Sanlam may, from time to time, request disabled members to submit medical reports and/or other documents to proof their continued disability.

  When a member is assessed for disability income benefits, the member's condition determines a review period / date of his current condition, e.g. end of 12 months or 18 months. The documentation and information necessary for the review (for longer periods) is requested via formal communciation (official letter), 6 months before the end of the review period, to allow members enough time to arrange for the medical information requested.

  If the requested medical information is not in Sanlam's possession by the date as stipulated in the formal communication, Sanlam will unfortunately suspend the member's monthly disability instalment and any other payments we make on behalf of the member/s (e.g. contribution waiver), until such time as we receive the requested information.

  Upon receipt of further medical information, confirming the member's inability to return to work, the monthly instalments will continue until the next review date (i.e. the receipt of 'new' medical information will determine the end of the next review period).

- Should the medical evidence found that the member is able to work, the monthly instalments can either reduce or payment ceases.

Claim assessment findings: repudiated / declined

In the case of a 'declined' assessment finding, the insured can dispute our decision.

In the event that the employee or employer is not satisfied with our decision, he/she may, within 90 days, provide us with written representations of his/her dissatisfaction, together with medical reports in support thereof.

Step 1: Contact the claims department

If a claim is declined it can be reassessed by another claims consultant on request. The insured / employer can forward representations to:

For disability-related claims:

E-mail address:	**DisabilityClaimBenefits.EB@sanlam.co.za**
Fax number:	(021) 947-3207
Postal address:	Sanlam Group Risk: Disability Claims, P.O.Box 1, Sanlamhof, 7532

Step 2: Contact the Sanlam Arbitrator

If the dispute is not resolved to the insured's satisfaction, he/she may submit his/her dispute to the Sanlam Arbitrator:

E-mail address:	**arbitrator@sanlam.co.za**
Fax number:	(021) 957-1786
Postal address:	Sanlam Arbitrator, PO Box 1, Sanlamhof, 7532

Step 3: Contact the Ombudsman for Long-term Insurance

If it is declined again the client can take their case to the Ombudsman for Long-term Insurance.

Should the insured not be satisfied with the determination given by Sanlam's Arbitrator he/she may submit a complaint to the Ombudsman for Long-term Insurance:

E-mail address:	**info@ombud.co.za**
Fax number:	(021) 674-0951
Postal address:	Ombudsman for Long-term Insurance, Private Bag X45, Claremont, 7735

Please note that any claim against the policy will prescribe 3 years after expiry of the 90 day period referred to above, should legal action not be instituted within this 3 year period.