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CAPITAL ALLIANCE
Group Risk
A division of Liberty Corporate

# Claim for a disability benefit

Section A

Tick where applicable ☑ **To be completed by the claimant** Please use a black pen and block letters

I, _____ (full names of claimant), hereby declare that I am the person assured under the scheme mentioned below. All the particulars given, whether in my handwriting or not, are to the best of my knowledge, true and complete. I accept full responsibility for any inaccuracies or omissions contained in this personal statement and I understand that the insurer may bring criminal or civil charges against me in the event that any such inaccuracies or omissions are discovered by the insurer.

I accept that I am hereby curtailing my right to 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 life assured, I irrevocably authorise Capital Alliance Group Risk:

(a) to obtain from any person, whom I hereby so authorise and request to give any information which Capital Alliance Group Risk deems necessary, and

(b) to share with other insurers that information and any 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 code form as may from time to time be decided by Capital Alliance Group Risk or by the operators of such data base.

**Please note:** The request for completion of the form in no way constitutes an admission of liability by Capital Alliance Group Risk.

## Claimant's personal statement Part 1

**Please note:** If there is not enough space provided on the form, please continue on a separate sheet of paper.

### 1. Claimant's personal details

Surname _____ First names _____

Member number _____ Date of birth D D M M Y Y Y Y

Identity number ☐☐☐☐☐☐☐☐☐☐☐☐☐ NB: please enclose a certified copy of your identity document

Scheme name _____ Scheme number _____

Details of driver's licence _____

Residential address _____ Postal code _____

Postal address _____ Postal code _____

Telephone number (work) (code) _____ Telephone number (home) (code) _____

Fax number (code) _____ Cellular _____

Email _____ Gender Male ☐ Female ☐

Income tax office _____ Income tax number _____

### 2. Details of occupation

2.1 Date when you started your current job D D M M Y Y Y Y

2.2 Date when you were last actively able to do this job D D M M Y Y Y Y

2.3 Position held _____

2.4 Please list your main duties. _____

## 2. Details of occupation (continued)

2.5 Apart from the above job, please supply a brief employment history, including previous positions held.

| Dates From | Dates To | Company | Position held | Type of work done (e.g. welding) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

2.6 Have you been able to perform any part of your main duties or another job since you first became disabled? Yes ☐ No ☐
If "Yes", please give details, including dates, job description and remuneration.

2.7 What was the highest level of schooling that you achieved? Standard/grade ☐ Year ☐

2.8 Please supply details of formal training and any courses which you have attended.

| Dates From | Dates To | Name of employer, college or institution | Qualifications obtained | Brief description of course content |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## 3. Details regarding impairment

3.1 List of complaints

3.2 When were these symptoms first noted?

3.3 How has this impairment limited you from performing any particular part of your main duties?

3.4 Please print the name, address and telephone number of your family doctor or the doctor who is currently attending to you.

3.5 Please supply details of all doctors, specialists and hospitals attended during the last five years (quote hospital number where applicable).

| Dates From | Dates To | Hospital or doctor | Address and telephone number | Patient number |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## 4. Particulars regarding income

If you receive, or expect to receive, any lump sum or periodic payment or any other benefit as a result of your impairment from any employer, insurance company, pension fund, state fund, compensation for occupational injuries and disease act, or any other source, please give details.

| Source of benefit (state name of company and your reference number) | Type of benefit (e.g. insurance, lump sum) | Amount |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Signature of claimant _____ Date D D M M Y Y Y Y

## Employer's statement Part 2

Tick where applicable ☑ To be completed by the employer Please use a black pen and block letters

**Please note:** If there is not enough space provided on the form, please continue on a separate sheet of paper.

## 1. Details of employer

1.1 (a) Name of employer _____

(b) Type of business _____

(c) Employer's address _____ Postal code _____

(d) Contact person at employer _____

(e) Direct telephone number of contact person ( c o d e ) _____

(f) Date claimant joined service D D M M Y Y Y Y

(g) Date claimant joined scheme D D M M Y Y Y Y

(h) Monthly pensionable income _____

(i) Month of last contribution D D M M Y Y Y Y
(Please include a copy of last payslip)

1.2 Please supply full details of the claimant's sick leave for the past two years, including copies of medical cer tificates for any absence exceeding two days. Also indicate days on which the claimant left work early (if available).

| Dates From | Dates To | Illness or injury | Working days absent |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

NB: Please include any details available regarding the claimant's illness/injury.

1.3 When were the symptoms first noted? _____

## 2. Details regarding the claimant's occupation

2.1 Position held by the claimant _____

2.2 When was the claimant last able to do his own occupation? D D M M Y Y Y Y

2.3 What was the claimant's job category? (Please mark the most applicable)

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

## 2. Details regarding the claimant's occupation (continued)

2.4 Summary of main duties (a) _____

(b) _____

(c) _____

2.5 Please describe the minimum physical abilities that a healthy individual requires to do this job (e.g. percentages, kilograms, metres, hours, numbers (how much), bags, sacks (what)).

| **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 movement | | | |
| Control of tools | | | |

2.6 (a) Please describe the minimum mental abilities that a healthy individual requires to do this job (e.g. describe the tasks requiring mental activity or attach examples).

| | Very often | Often | Seldom |
|---|---|---|---|
| Literacy | ☐ | ☐ | ☐ |
| Numeracy | ☐ | ☐ | ☐ |
| Memory | ☐ | ☐ | ☐ |
| Problem solving | ☐ | ☐ | ☐ |
| Decision making | ☐ | ☐ | ☐ |
| Specialised knowledge | ☐ | ☐ | ☐ |

(b) Summary: In view of the claimant's current medical condition, please describe the mental effort it takes to do this job (e.g. memorising, calculating etc.).

_____

2.7 Please describe the minimum communication skills that a healthy individual requires to do this job (e.g. describe the aspects requiring communication).

| | Very often | Often | Seldom |
|---|---|---|---|
| Speaking | ☐ | ☐ | ☐ |
| Writing | ☐ | ☐ | ☐ |
| Listening | ☐ | ☐ | ☐ |
| Reading | ☐ | ☐ | ☐ |
| Public speaking | ☐ | ☐ | ☐ |

## 2. Details regarding the claimant's occupation (continued)

2.8 How often does the claimant work in the following conditions?

| | Very often | Often | Seldom |
|---|---|---|---|
| Dust | ☐ | ☐ | ☐ |
| Vibration | ☐ | ☐ | ☐ |
| Noise | ☐ | ☐ | ☐ |
| Fumes | ☐ | ☐ | ☐ |
| Heat | ☐ | ☐ | ☐ |
| Cold | ☐ | ☐ | ☐ |

2.9 How much of the claimant's time is spent in the following conditions?

| | Percentage / hours |
|---|---|
| Outdoors | |
| Indoors | |
| Height | |
| Depth | |
| Wet areas | |
| Dry areas | |

2.10 What are the standard working hours per day? _____

2.11 Have any attempts been made to adapt the claimant's work environment or duties to accommodate his/her condition? Yes ☐ No ☐

If "Yes", please provide full details. _____

_____

2.12 Has any attempt been made to accommodate the claimant in an alternative position? Yes ☐ No ☐

If "Yes", please provide full details. _____

_____

2.13 Has the claimant partially or fully recovered, or is the claimant expected to partially or fully recover? Yes ☐ No ☐

If "Yes", when did or when is the claimant expected to return to work? D D M M Y Y Y Y

## 3. Payment instructions

In terms of the policy, payment is always made directly to the Employer. Proof of banking details of the Employer will be requested if claim is approved.

3.1 Payment to be made directly to Employer (name of employer):

3.2 Name of the account holder _____

Postal address of account holder _____ Postal code _____

Name of banking institution _____ Account number _____

Branch name _____ Branch code _____

3.3 Waiver of premium benefit payment, if applicable, will be payable to the Employer.

It is hereby declared that, to the best of our knowledge, the particulars above are true and complete.

## 3. Payment instructions (continued)

Company stamp

Name _____

Position held _____

Date D D M M Y Y Y Y

Direct telephone number (for enquiries) ( c o d e ) _____

Fax number ( c o d e ) _____

Cellular number _____

Email address _____

Signature _____

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# Confidential medical report by attending physician

Section B

Tick where applicable ☑ **To be completed by the attending physician** Please use a black pen and block letters

**Please note:** If there is not enough space provided on this form, please continue on a separate sheet of paper.

**Dear Claimant**

Carefully read the information in the table below before having the disability claims package completed by your physician. You are required to pay the physician for completing the medical report/s.

Capital Alliance would prefer all medical reports to be completed by the attending specialist. In cases where a specialist is not consulted, a report from the attending general practitioner will be accepted. It is then more likely that additional medical reports will be requested.

| Guideline of which medical practitioner should complete the medical report/s for your condition | |
|---|---|
| HIV / AIDS | Confidential medical report by **attending general practitioner**, CD4 count and HIV test results |
| Alzheimer's disease | Confidential medical report by **attending neuropsychologist**, including copies of all tests and reports done |
| Arthritis, including rheumatoid arthritis | Confidential medical report by **attending rheumatologist**, including copies of all tests and reports done |
| Backache or any other musculoskeletal disorder such as rotator cuff syndrome | Confidential medical report by **attending orthopaedic surgeon**, including copies of all disorder such as rotator cuff syndrome tests and reports done, especially X-ray reports |
| Blindness | Confidential medical report by **attending ophthalmologist**, including copies of all tests and reports done, especially visual acuity readings |
| Cancer | Confidential medical report by **attending oncologist**, including copies of all tests and reports done, especially biopsy tests / histology reports |
| Cardiac conditions, such as myocardial infarction (heart attack) | Confidential medical report by **attending cardiologis**t, including copies of all tests and reports done, especially ejection fraction |
| Chronic fatigue syndrome | Confidential medical report by **attending specialist**, including copies of all tests and reports done |
| Cirrhosis of the liver | Confidential medical report by **attending specialist,** including copies of all tests and reports done |
| Deafness | Confidential medical report by **attending ENT specialist**, including copies of all tests and reports done, especially hearing test results |
| Diabetes mellitus | Confidential medical report by **attending specialist**, including copies of all tests and reports done, especially most recent HbA 1 c |
| Epilepsy | Confidential medical report by **attending neurologist**, including copies of all tests and reports done, especially CAT scans and EEG results |
| Multiple sclerosis | Confidential medical reports by **attending neurologist**, including copies of all tests and reports done |
| Paraplegia | Confidential medical report by a**ttending orthopaedic surgeon / neurosurgeon / neurologist**, including copies of all tests and reports done |
| Parkinson's disease | Confidential medical report by **attending neurologist / physician**, including copies of all tests and reports done |
| Psychiatric conditions | Confidential medical report by **attending psychiatrist**, including copies of all tests and reports done and details of treatment regimen |
| Renal failure or other related conditions | Confidential medical report by **attending nephrologist**, including copies of all tests and reports done, especially renal function tests |
| All respiratory conditions, such as asthma, emphysema and chronic obstructive airways disease | Confidential medical report by **attending pulmonologist**, including copies of all tests and reports done, especially lung function tests and X-ray reports |
| Skin conditions | Confidential medical report by **attending dermatologist**, including copies of all tests and reports done |
| Stroke (cerebrovascular accident) | Confidential medical report by **attending neurologist**, including copies of all tests and reports done, especially CAT scans |
| Tuberculosis | Confidential medical report by **attending general practitioner**, including copies of all tests and reports done, especially X-ray reports and sputum test results |
| Trauma or accident | Confidential medical report by **attending surgeon**, including copies of all tests and reports done |

In the event that your condition is not mentioned above, please contact Capital Alliance disability claims assessor for clarification on who should complete your medical report.

**Dear Doctor**

Capital Alliance has received an application for a disability claim for this member and would appreciate your completing this confidential medical report. It is essential that you complete this form as fully as possible to prevent any unnecessary delays.

**Please note:**
- **The cost of completing this medical report must be borne by the claimant.**
- **If you have any reports of previous investigations to substantiate the diagnosis, please supply copies.**
- **The request for completion of this form in no way constitutes an admission of liability by Capital Alliance.**
- **If the claimant is only consulting a general practitioner, Capital Alliance suggests he consults a specialist at his/her nearest provincial hospital for completion of the forms where reports are to be completed by a specialist.**

Purpose: To assess the claimant's impairment (medical assessment), and to ascertain:
- change in functional capacity due to illness or injury
- diagnosis
- optimal medical treatment

## 1. Claimant's personal details

Surname _____ First names _____

Member number _____ Date of birth D D M M Y Y Y Y

Identity number | | | | | | | | | | | | | |

Employer name _____

## 2. History of impairment

2.1 What is the claimant's Height _____cm Weight _____kg

2.2 When did the claimant first consult you? D D M M Y Y Y Y

2.3 On what date did the first symptoms of the condition claimed for appear? D D M M Y Y Y Y

2.4 If you are still attending to the claimant, when was the last consultation? D D M M Y Y Y Y

2.5 Please complete the schedule below

| Date | Reason for consultation | Diagnosis | Treatment | Result / prognosis |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

2.6 Have clinical investigations been performed to determine the condition? Yes ☐ No ☐

If "Yes", comment on the results of all tests/examinations performed to confirm diagnosis (please include copies)

_____

_____

2.7 (a) How has the claimant's condition been treated over the past 12 months? (Discuss treatment regimen prescribed)

| Date | Treatment (medication and dosage) | Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

2.8 (a) Is future surgery/treatment planned? (if applicable) Yes ☐ No ☐

(b) If "Yes" what type of surgery/treatment and when?

_____

_____

2.9 Notwithstanding the treatment regimen described above, and the envisaged cost thereof, what further treatment would you recommend to improve the claimant's condition and/or activities of daily living?

_____

_____

2.10 Please provide a full description of any related conditions that the claimant has

2.11 Please provide a full description of any related symptoms that the claimant has

2.12 (a) Do you know of any other factors (e.g. previous illness or injury, hazardous pastimes or pursuits, habits or self inflicted injuries) that may have contributed in any way to the claimant's impairment?

Yes ☐ No ☐

(b) If "Yes", please comment fully.

2.13 (a) In your opinion, when will the claimant be able to go back to work?

Part-time Date D D M M Y Y Y Y Duties

Full-time Date D D M M Y Y Y Y Duties

(b) If the claimant has already recovered and returned to work, please give the date of his/her return to work. D D M M Y Y Y Y

2.14 Please provide any additional information which you feel will assist Capital Alliance in the assessment of this claim (if there is not enough space provided on this form, please continue on a separate sheet).

**• Have you included copies of all tests and reports?** **Yes** ☐ **No** ☐

Additional comments:

## 3. Details of medical attendant

Doctor's name and address (please print)

Telephone number ( c o d e ) Fax number ( c o d e )

Cellular number Practice number

Email address Date D D M M Y Y Y Y

Qualifications

I declare and warrant that all information provided by me in this confidential medical report is complete and true. I accept full responsibility for any inaccuracies or omissions contained in this confidential medical report and I understand that the insurer may bring criminal or civil charges against me in the event that any such inaccuracies or omissions are discovered by the insurer.

Doctor's signature