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

Protection of Personal Information Disclosure

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

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

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

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

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

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

Other parties that may receive the Personal Information:

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

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

Print form Save form

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

1 Contents

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

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

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

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

- **Leave records: Please provide copies of all leave records for the past 12 months.** *Sick leave should be clearly marked.*
- **Salary statement:** *Please provide a copy of the insured's salary statement as on the last date on which the insured performed his/her duties.*
  In the case of an insured who receives a commission based salary, we require the past 3 year's salary statements.
- **Identity document:** *Please provide a copy of the insured's identity document.*
- **Job description:** *Please provide a comprehensive (typed) copy of the insured's job description at the time of disability.*

2 General

- It is the insured's responsibility to prove that he/she is disabled in terms of the policy provisions.
- The insured has the initial responsibility of providing medical and other documentary evidence of disability at his/her own cost.
- The insured is obliged to submit whatever medical or other information Sanlam may reasonably require.

3 Disclaimer

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

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

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

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

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

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

A Particulars of fund/scheme

Name of fund/scheme _____ Code _____

Name of branch/participating employer _____

E-mail address _____

Telephone number ( ) _____

B Personal details of the insured

Full names and surname _____

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

Marital status: Single ☐ Married ☐ Divorced ☐ Co-habiting ☐ Widowed ☐

Identity number _____

Educational qualifications _____

Further courses/training completed _____

_____

Particulars of membership

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

Date of entering service _____ Date of permanent appointment _____

Date of commencement of membership _____

If the scheme has been underwritten by Sanlam for less than one year, please complete the following:

Type of benefit and cover the insured enjoyed at the previous insurer

Type of benefit _____ Cover amount R _____

Provide the date from when the insured was covered at the previous insurer? _____

Salary information for the past 3 years

Date of salary received *(dd/mm/ccyy)*	**Annual salary (R)***	**Annual cost to company salary (R)**

***** *This must be the salary on which the premiums paid to Sanlam, are calculated.*

C Medical Aid Premium Waiver benefit

Note: *The following information must only be provided if the policy makes provision for the benefit and if a claim for the Medical Aid Premium Waiver Benefit must be considered with the disability of the insured.*

Name of insured's medical aid scheme _____

Particulars of dependants	Name and surname	Date of birth *(dd/mm/ccyy)*	Amount of medical aid premium * (R)
Principle member			
Spouse			
Child (1)			
Child (2)			
Child (3)			
Child (4)			

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

Important: *Please inform Sanlam in case any of the information supplied with regard to the Medical Aid Premium Waiver Benefit changes.*

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

Signed by the employer on behalf of the fund/scheme

Initials and surname _____

Designation _____

Signature _____

Place _____

Date _____ *(dd/mm/ccyy)*

Particulars of insured's occupation

Note: *This section must be completed in consultation with the insured's manager, supervisor or any other person who is familiar with the circumstances.*

Name of supervisor _____

Telephone number of supervisor (_____) _____

Email address of supervisor _____

Name of contact person at Human Resources Department _____

Telephone number of contact person (_____) _____

Email address of HR contact person _____

Insured's occupation _____

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

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

Please list the insured's main duties:

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

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

Job demands	%
Physical	
Supervisory	
Administrative	
Total	100%

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

Particulars of insured's occupation *(continued)*

Please list the physical aspects of the occupation

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

How often does the insured work in the following conditions?

Work conditions	How often?	Work conditions	How often?
Indoors		Dust	
Outdoors		Vibration	
High areas		Noise	
Underground		Fumes	
Wet areas		Extreme heat	
Cold storage areas		Walking on uneven surfaces	
Driving a vehicle		Operate machinery	
Type of vehicle:		Estimate distance covered per day/week/month	

Last date of performing his/her duties _____ *(dd/mm/ccyy)*

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

If "Yes", please provide details _____

How often are you in contact with the insured ? _____

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

If "Yes", provide the following particulars:

In which capacity? _____

Description of work _____

Accommodated work duties _____

Please provide a description of the accommodated duties.

Working hours _____ Working environment _____

From which date? _____ Until which date? _____

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

Average remuneration per month in this position: R _____

Particulars of insured's occupation *(continued)*

Did the insured accept the position? Yes ☐ No ☐

If "No", please provide reasons: _____

_____

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

_____

_____

_____

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

If "Yes", please provide brief details _____

_____

_____

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

Initials and surname _____

Designation _____

Signature _____

Place _____

Date _____ *(dd/mm/ccyy)*

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

Title _____ Full names _____

Surname _____

Previous name *(if applicable)* _____

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

Country of birth _____

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

Number _____ Country of issue _____

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

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

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

* If "Yes", please give other country _____

Address and contact numbers:

Residential address _____

_____ Postal/Zip code _____

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

_____ Postal/Zip code _____

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

e-mail address _____

Next of kin contact details:

Title _____ Full names _____

Surname _____

Relation: _____

Contact number ( ) _____

Email address: _____

1(a) Educational History

Highest school qualification _____

Other training/qualifications _____

_____

_____

1(b) Occupational history

- Please give a detailed description of your career history, including your present occupation. The exact date(s) on which service commenced and was terminated, are required:

Name and address of employer	Period in service / From *(dd/mm/ccyy)*	Period in service/ To *(dd/mm/ccyy)*	Nature of work	Reason for leaving

1(b) Occupational history *(continued)*

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

2 Nature of disability

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

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

  ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

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

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

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

  ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

3 Medical care

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

  Please state approximate number of visits: _____

3 Medical care *(continued)*

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

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

Medication	Dosage

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

  If "Yes", please provide details

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

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

- How are you coping with this health problem?

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

- How do you spend your days?

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

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

  ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

4 Disability due to an accident

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

  Circumstances causing the accident

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

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

5 Income

- Are you receiving or do you expect to receive any benefit, salary, pension or compensation of whatever nature as a result of or during your disability? Yes ☐ No ☐
  (Including income from any employer, partner, assurance company, a pension or retirement annuity fund, RAF, COIDA, any governmental fund or any other source.)

  If "Yes", please give the following details:

  Regular amounts *(including life annuities)*

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

  Disability amounts included in ordinary assurance at any other companies *(regardless of whether claim has been submitted already)*

Name of company	Amount (R)	Date of payment *(dd/mm/ccyy)*

- Tax particulars

  Income tax reference number _____

  Income tax office to which last return was rendered _____

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

  If "Yes", please describe in detail _____

  _____

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

  If "Yes", please complete the following:

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

6. Banking details

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

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current ☐ Savings ☐ Transmission ☐

7 Disclaimer

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

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

8 Consent for Disclosure of Confidential Information and Declaration

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

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

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

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

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

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

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

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

Signature of insured _____

Full name(s) and surname of witness _____

Signature of witness _____

Guidelines for a confidential medical report

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

Dear Doctor,

Sanlam is in the process of assessing the extent of the patient's disabilities, in view of a claim for disability benefits. To assist us in making a justified decision, we require a report regarding the functional impairment of the patient.

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

Please note that the patient's identity needs to be established above doubt before proceeding with the examination. Confirm the document/means used to establish the patient's identity, in your report.

Any costs relating to this consultation and medical report is for the patient's account. Should you require additional test / evaluations to establish the patient's functional impairment, the patient will also be responsible for settling these.

Guidelines for a medical report on functional impairment

- Diagnosis (DSM IV/V for psychiatric conditions)
- Date of onset and course of disease
- Severity, perpetual factors, secondary gain
- Current clinical findings. Please provide a detailed description.
- Treatment
  - Treatment modalities
  - Types of medication and dosage
  - Duration of treatment
  - Therapeutic procedures
  - Rehabilitation
  - Hospitalisation
  - Dates of consultations
- Response to treatment and side effects
- Compliance with treatment
- Complications that are permanent
- Special investigations (e.g. ECG, X-rays, scans, blood tests, laboratory test results, etc.)
- Prognosis with optimal treatment
- Influence on lifestyle, activities of daily living and working capability
- Special requirements
  - Cardiovascular: NYHA classification, exercise capacity, stress ECG, ejection fraction, echocardiogram, other
  - Respiratory: dyspnea-grading(ATS),exercise capacity, (METS or VO2 max.) vitalogram pre-and post-inhalation (3 attempts), chest X-ray, single-breath diffusion test (Dco) in cases of interstitial lung disease
  - Orthopaedic: X-ray and stress views, MRI or CAT scans, other (eg. nerve conduction tests)
  - Neurological: MRI, CAT scan results, EKC other
  - Surgery: Surgical report
  - Psychiatric: social functioning, concentration, psychometric tests in cases of cognitive impairment, frequency and dates of consultations
  - Immunocompromised conditions: blood tests, CD4 count and viral load

Print form Save form

EB2880E

Confidential Medical Report: Disability

Dear Doctor,

Thank you for your time.

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

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

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

Please see the attached Guideline document (page 6).

Scheme and personal details

Name of fund/scheme _____

Name of employer _____

Name of insured _____

Insured's date of birth _____ Identity number _____

Membership number _____

Medical practitioner information

Full names and surname _____

Address _____

_____ Postal code _____

Email address _____

Qualification: _____

Practice number _____ Contact telephone number _____

1. Course of illness

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

Most recent examination date _____ (ddmmccyy)

Previous consultations:

Date *(ddmmccyy)*	Diagnosis	Treatment

When was the diagnosis first made? _____ (ddmmccyy)

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

Current complaints from the claimant's point of view:

_____

_____

_____

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

What permanent complications of the condition have you identified?

Specialist consultations and special investigations done:

Specialist or investigation done	Date (ddmmccyy)	Result

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

Current medical examination:

Weight: _____ Height: _____ BP: _____

Pulse: _____ Cholesterol: _____ Blood glucose: _____

2. Treatment

Current medication

Name/type	Dosage	Duration

Previous medication

Name/type	Dosage	Duration

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

Type	Name and contact of doctor/therapist	Period of treatment

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

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

3. Prognosis

Please give your opinion on the prognosis:

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

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

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

Full time _____ Part-time _____

4. Functional impairment

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

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

Additional questions

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

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

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

Signature of medical practitioner _____

Date _____ (ddmmccyy) Place _____

Please provide practice stamp