MONTHLY DISABILITY PAYMENT FORM

Request to make payment to claimant directly

Thank you for choosing Hollard Group Risk. The information you provide in this form will assist us to make disability payments directly to the claimant.

Please return to: Hollard Group Risk, Florence House, 22 Oxford Road, Parktown 2193 or PO Box 87419, Houghton 2041. Tel: (011) 351 5000. Email: hgrannuityclaimpayment@hollard.co.za.

SECTION A: SCHEME DETAILS

Employer name:

Policyholder:

Policy number:

Member number:

SECTION B: CLAIMANT DETAILS

First name(s):

Surname:

Date of birth: dd/mm/yyyy

ID / passport number:

Country of origin (if not RSA):

Tax reference number:

Residential address:

Code:

Postal address:

Code:

Email address:

Contact number:

SECTION C: DISABILITY CONTACT PERSON DETAILS

Details of the contact person for disability claim and payment related correspondence

☐ Employer ☐ Claimant ☐ Broker ☐ Fund Administrator

Contact person:

First name(s):

Surname:

Email address:

Contact number:

Effective date:

SECTION D: CLAIMANT BANKING DETAILS

Name of bank:

Name of account holder:

Account type:

Account number:

SECTION E: FUND MEMBERSHIP AND PAYROLL DETAILS

Is the claimant exiting / withdrawing from the fund:

☐ No

☐ Yes, exit date: dd/mm/yyyy

Is the employer terminating the claimant from their payroll:

☐ No

☐ Yes, payroll termination date: dd/mm/yyyy

SECTION G: EMPLOYER CONTRIBUTION WAIVER

Employer contribution waiver is payable to:

☐ Fund ☐ Employer ☐ Claimant (payment into an *RA)

- When a claimant withdraws from the fund for any reason, the employee benefit continues to be paid directly to the claimant.
- Payment of the employer contribution waiver to the claimant for an RA is only possible if claimant has exited the fund.
- The employer waiver will continue to be paid only if the claimant opens a new RA, or the existing RA continues.
- The claimant has 3 months to open the new RA.
- The employer waiver will be paid to the claimant for payment into the RA.
- The claimant has to send proof of ongoing RA fund membership to the insurer annually.
- The employer waiver will be paid to the claimant from the date of withdrawal from the fund, provided that the new RA is opened within three months from date of withdrawal.

**RA: Retirement Annuity*

SECTION H: EMPLOYEE CONTRIBUTION

Is an employee contribution deduction required:

☐ No, please proceed to Section I

☐ Yes, please complete the remainder of Section H

Pension Fund: ☐ Provident Fund: ☐ Contribution percentage: ____ %

Contact person for payment: _____

Email address: _____

Contact number: _____

SECTION I: CONSENT

I hereby confirm that I understand the reason for the completion of this form and give Hollard Group Risk consent to use the information contained in this form to process the request to pay the claimant directly.

I have attached the required supporting documents listed below:

☐ • Bank account verification to support information provided in Section D (i.e. official bank statement not older than 3 months, signed or stamped by the bank).

☐ • Employer contribution waiver details:
   a. For payment of waiver to fund: A letter on a letterhead of the fund stating the correct fund banking details.
   b. For payment of waiver to employer: A letter on a letterhead of the employer stating the correct employer banking details.
   c. For payment of waiver to the claimant (for a retirement annuity): A copy of the retirement annuity policy.

☐ • Employee contribution: A letter on a letterhead of the fund stating the correct banking details.

Employer signature

Claimant signature

Date signed

Date signed