DISABILITY CLAIM FORM: MEMBER & EMPLOYER

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

This form is required for the application of disability benefits.

In the event that the member is incapacitated and unable to complete this form, the sections for the member must be completed by the member's caretaker and/or the employer. We require an affidavit confirming the member's inability to complete and sign the member's personal declaration.

It is essential that all claim forms are fully completed to prevent any unnecessary delays due to missing or incomplete information.

It is the employer's responsibility to compile all the documents required and to submit them to Hollard Group Risk. If we ask for an original certified copy of a document we will not accept a certified copy of a previously certified copy.

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Group Risk.

PRIVACY STATEMENT

We respect the confidentiality of your personal and medical information as well as your privacy. If necessary, we may need to share either your and/or the insured's personal or medical information, or both, with third parties. These third parties are other insurance and/or reinsurance companies, or service providers that may assist us in assessing and managing the risk or servicing you. We impose the same strict confidentiality standards on these third parties as is applied by us. By providing the required personal and medical information, and signing this form, you hereby confirm that you consent to us processing and sharing your and/or the disabled person's personal and medical information with other third parties. We will treat this information with caution and we have put reasonable security measures in place to protect it. The information provided will only be used for its intended purpose and will not be shared within the Hollard Group or another organisation for marketing additional products and/or services to you.

SECTION A: POLICY DETAILS

Employer:

Policyholder:

Policy number:

Membership / Employee number:

SECTION B: EMPLOYER'S DETAILS

Name of company:

Physical address:

Code:

Contact person:

Job title:

Contact number:

Email address:

SECTION C: MEMBER'S PERSONAL DETAILS (to be completed by the employer or member)

First names:	
Surname:	
Identity number:	
Date of birth:	
Gender:	
Residential address:	
	Code:
Contact number:	
Alternative contact number:	
Email address:	
Tax Reference number:	

SECTION D: MEMBER'S REPORT ON EDUCATION AND TRAINING (to be completed by member)

1. What is the highest level of education that you completed?

2. Please give details of formal schooling, training, qualifications and any courses which you completed:

Date from	Date to	Name of School / Institution	Grade / Qualification obtained

SECTION E: MEMBER'S REPORT ON EMPLOYMENT (to be completed by the member)

1. What is your current position (job / occupation)?
2. When did you start working in your current position?
3. When were you last able to fully perform your current position?
4. When did you stop working?
5. Are you still receiving a salary? Yes ☐ No ☐

If "No", when did you receive your last salary?

6. Have you been able to perform any of your main occupational duties since the onset of your condition?

If "Yes", please provide details, including dates, and a description of your occupational duties and remuneration

Yes ☐ No ☐

7. Have you been able to perform in any other / alternative occupation since the onset of your condition?

If "Yes", please provide details, including dates, and a description of your occupational duties and remuneration.

Yes ☐ No ☐

8. When do you expect to be able to resume work on a:

Part-time basis? _____ Full-time basis? _____

9. Apart from your current position, please supply your employment history:

From	To	Company	Position held	Type of work done	Reason for change

SECTION F: MEMBER'S REPORT ON CLAIM (to be completed by the member)

1. Describe what you think is preventing you from performing your duties:

2. When did your symptoms start? _____

Please describe these symptoms:

3. Has any of the following contributed in any way to your condition?

	Yes	No	Details
Accident			
HIV:			
Previous illness or injury:			
Hazardous pursuit or pastime:			
Habits e.g. alcohol consumption:			
Self-inflicted injuries:			

4. If this claim has arisen from an accident please answer the questions below.

The accident occurred at (place):

On (date):

Describe how the accident happened:

5. When did you first consult a medical practitioner in respect of your current condition?

6. Please provide details of the first medical practitioner consulted

Name:

Telephone number:

Emai:

Address:

7. Please provide details of your usual family doctor

Name:

Telephone number:

Email:

Address:

8. Provide details of all other medical practitioners including specialists consulted in connection with this condition.

Name:

Specialty:

Telephone number:

Name:

Specialty:

Telephone number:

Name:

Specialty:

Telephone number:

9. Have you ever suffered from any other form of impairment or ever been declared disabled from employment before?

Yes (please provide details below) ☐ No ☐

10. Have you been referred to any health care professionals e.g. Physiotherapist, Occupational Therapist, Psychologist or other medical specialists?

Yes (please provide details below) ☐ No ☐

Name	Specialty	From	To	Treatment

11. Have you had any tests, X-rays or special investigations relating to your condition or any other impairment?

Yes (please provide details below) ☐ No ☐

Date	Doctor	Investigation	Hospital	Outcome

12. (a) How has your condition been treated?

Date	Therapy / Medication	Description / Dosage

(b) Is future surgery planned / required / anticipated

Yes (please provide details below) ☐ No ☐

13. Has there been any improvement in your condition?

Yes (please provide details below) ☐ No ☐

14. How has this condition affected your ability to perform your activities of daily living?

	Able	With help	Unable
Mobility: The ability to move indoors from room to room on level surfaces.	☐	☐	☐
Transferring: The ability to move from a bed to an upright chair or wheelchair and *vice versa.*	☐	☐	☐
Eating: The ability to feed oneself once food has been prepared and made available.	☐	☐	☐
Washing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.	☐	☐	☐
Dressing: The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	☐	☐	☐
Toileting: The ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate.	☐	☐	☐

15. Please describe how you currently spend your days:

16. Have you resided outside South Africa in the past year?
AND/ OR
Do you intend to reside outside South Africa in the future?

Yes (please provide details below) ☐ No ☐

From	To	Country	Reason

17. Please provide details of any benefit, salary or remuneration that you have received or expect to receive as a result of your incapacity including details of salary, benefits from an insurance company, pension fund, state fund or any other source.

Source of benefit	Name of company and your reference number	Amount
Disability benefit		
Salary		
Commission		
Other employer earnings		
Pension		
COID/ WCA benefits		
Other insurance benefits		
Other source		

SECTION G: EMPLOYER'S REPORT (to be completed by the employer)

1. When did the member join the company?

2. When did the member join the disability benefit scheme?

3. Is the member a full-time employee?

4. Date appointed as full-time employee?

5. Month last risk premium was paid for (mm/yyyy):

6. What was the member's salary as at the date that he/she was no longer able to fulfill the requirements of his/her occupation?

7. What was the effective date of this salary?

8. Is the member still receiving a salary? Yes ☐ No ☐

If yes, please advise 1) the current salary, 2) if the current salary is different - the reason for the difference, and 3) if the current salary is different - from which date this new salary was effective?

Salary:

Reason: Date:

Until when do you intend to pay the member this salary?

9. When was the member last able to perform his/her duties in full?

10. Is the member still working? If "Yes", please provide details of current activities: Yes ☐ No ☐

11.When do you expect the member to resume work on a:

(a) Part-time basis? (b) Full-time basis?

12.What do you understand to be affecting the member's ability to perform the duties of his/her current occupation?

13. How is the performance of the member's occupational duties being affected by his/her condition?

14. What accommodations or adaptations can you make within the company to keep the member at work?

15. If you have any steps to assist the member to continue to work within the company, please provide details:

16. If this claim has arisen from an accident at work please answer the questions below.

The accident occurred at (place):

On (date):

Please provide a brief description of your understanding of how the accident happened?

SECTION H: OCCUPATIONAL INFORMATION (to be completed jointly by the employer and the member)

1. Please state the member's current job title or position held?

2. Is the member responsible for the supervision of any staff? Yes ☐ No ☐

If "Yes", please state number of staff supervised:

3. Please select the job category that would be most applicable to your position.

- ☐ Managerial
- ☐ Supervisory
- ☐ Clerical
- ☐ 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)
- ☐ Other (Please provide description in the space provided below)

4. Please provide a brief summary of the member's main dutiies their current role?

5. What is the minimum training /education required to perform the member's occupation?

School		Standard	
Technical		Diploma	
Professional		Degree	
On the job training		Months	

Other:

6. Please complete the questions below on the member's work environment.

6.1 Please describe the work conditions:

Work Conditions	**Details (e.g. meters, percentage of time spent, description of work condition)**
Indoors	
Outdoors	
Vibration	
Heights	
Depths	
Humid / cold temperatures	
Rough terrain	
Underground	
Balance required	
Dust	
Noise	
Wet	
Fumes	
Other	

6.2 Please provide the details of any known safety hazards in the member's occupational duties:

6.3. Please provide details of any personal protective equipment required to perform the member's occupation:

7. What are the daily standard working hours?

Week: Start time ☐ End time ☐

Weekend: Start time ☐ End time ☐

8. If shift work required, please provide details of alternate shift times:

9. Please complete the below on the physical demands of the member's occupation:

Activity	Never	Sometimes	Often	Always	Hours per day
Sitting	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Walking on even terrain	☐	☐	☐	☐	☐
Walking on uneven terrain	☐	☐	☐	☐	☐
Use of both hands	☐	☐	☐	☐	☐
Use of fine coordination	☐	☐	☐	☐	☐
Lifting weights	☐	☐	☐	☐	☐
Carrying weights	☐	☐	☐	☐	☐
Pushing weights	☐	☐	☐	☐	☐
Engaging in physical labour	☐	☐	☐	☐	☐
Reaching above shoulder height	☐	☐	☐	☐	☐
Working in cramped conditions	☐	☐	☐	☐	☐

10. Which tools, machines, materials and equipment are used to perform the member's occupational duties?

11. Please describe the minimum mental abilities that a healthy individual requires to perform the member's occupational duties by completing the table below.

Abilities required	Very often	Often	Seldom	Examples of tasks requiring these abilities
Literacy				
Numeracy				
Memory				
Problem solving				
Decision making				
Specialised knowledge				
Concentration				
Planning				
Calculations				
Administrative tasks				

12. Please describe the minimum communication skills required to perform the member's occupational duties by completing the table below.

Communication Skills required	Very often	Often	Seldom	Aspects of occupational duties requiring these communication skills
Speaking				
Writing				
Listening				
Reading				
Public speaking				

13. Only complete this question if driving is a component of your occupational duties.

License code(s) required:

Type of vehicle(s) driven:

Average distance driven: per day Km per week Km per month Km

14. Only complete this question if flying is a component of your occupational duties. Type of aircraft flown:

Average distance flown per week Km Average number of hours flown per week Km

15. Only complete this question if diving is a component of your occupational duties.

Certification:

Average depth per week: m Average number of dives per week:

Any mixed gasses used:

16. Only complete this question if mining is a component of your occupational duties.

Certification:

Are you involved with blasting or explosives? Yes No

If yes, please provide details of how you are involved and how often:

What type of mining is undertaken? Opencast Underground

If "Underground":

How often do you go underground:

Average number of hours spent underground per week:

What activities are performed whilst underground:

17. Only complete this question if going out to sea is a component of your occupational duties.

Seamen's license:

How often: Distance:

What activities are performed whilst out at sea:

SECTION I: DECLARATION (to be signed and dated by the employer)

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Group Risk. In the event that this claim or any supporting claim documentation is found to be fraudulent or misrepresented, Hollard Group Risk reserves the right to proceed with the appropriate action against the member. I confirm that have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information. If I am agreeing to the aforementioned on behalf of someone else, I confirm that I have the necessary approval and/or mandate to do so.

Name and Surname of authorised signatory
(individual authorised to sign on behalf of the policyholder)

Date signed

Authorised signatory identity number

Designation

Authorised signatory contact number

Email address

Authorised signatory signature

SECTION J: DECLARATION (to be signed and dated by member)

I, the person insured under this policy, declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Group Risk. I agree that all the written statements, reports and affidavits submitted in support of this claim shall constitute part of this claim.

I agree that benefits payable in respect of this claim shall be forfeited if I, or any person acting on my behalf with my consent, have withheld any material fact or submitted any false information in respect of this claim, and that Hollard Group Risk reserves the right to proceed with the appropriate action against the member as well as any beneficiary or third party that received a benefit (if applicable).

Accepting that I am thereby limiting my right of privacy, but to assist with the assessment of my claim I irrevocably authorise Hollard Group Risk:

a) to obtain from any person, whom I hereby so authorise and request to give, any information which Hollard Group Risk deems necessary, and
b) to share with other insurers that information and any information contained in this claim form or in any related 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 Hollard Group Risk or by the operators of such data base.

I authorise any medical practitioner, hospital or other person to provide Hollard Group Risk with any information required relating to my medical history, my injury, my employment history and/or any other information which may be necessary for Hollard Group Risk's consideration of the claim. I also provide consent that any information provided by me may be verified against other sources or data bases (e.g. including credit bureaus). Furthermore I have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information. If I am agreeing to the aforementioned on behalf of someone else, I confirm that I have the necessary approval and/or mandate to do so.

Member's signature

Date signed

In the event that the form was completed on behalf of the member:

Caretaker name and surname

Caretaker identity number

Caretaker contact number

Caretaker email address

Caretaker signature

Date signed