FedGroup Life

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DISABILITY COVER CLAIM

INSTRUCTIONS:

1. This form must be completed by the Claimant and a Power of Attorney or a Curator Bonis in a medical situation whereby it is not possible for the Claimant to do so.
2. To avoid administration delays, please ensure this form is completed in full.
3. Please use one letter per block, complete with black ink and print clearly.

1. POLICY DETAILS:

Name of Group Risk Policy

Policy no G A

Name of Employer

2. YOUR CHECKLIST:

- Disability Cover Claim Form
- Certified copy of the Claimant's ID (photo must be visible)
- Copies of the Claimant's last two months salary slips
- All payments are to be made into a bank account. We require proof of bank details (cancelled cheque / bank statement)
- Disability Cover Claim Medical Report, together with supporting medical evidence to be completed by a treating Medical Examiner

3. EMPLOYEE DETAILS:

Title

Initials

Full name/s

Surname

Cell no

Tel no

Email

Physical address

Code

Postal address

Code

ID no

Codes of all drivers licences

Income Tax Number

Income Tax Office

Initial

4. CLAIMANT HISTORY:

EDUCATION HISTORY

Qualification	Year completed	Institution

EMPLOYMENT HISTORY

Please provide us with a history spanning throughout your career, including your present occupation.

Name and address of Employer(s)	Date		Occupation / Job title	Remuneration
	From	To		

On which date were you last actively able to perform the duties of your occupation due to your medical condition?

DD MM YYYY

What is/was your full time occupation?

Please specify the percentage of time spent on:

Administrative duties				%
Manual duties				%
Supervisory duties				%
Travel (car, truck etc)				%
				100%

Please list your main duties:

1.
2.
3.
4.

What is your current employment status? Please tick box.

	Working full time		Working part time		On sick leave
	On unpaid leave		Laid off / retrenched		Dismissed

What alternative occupation(s) do you consider yourself qualified for and capapable of performing despite your limitations, but taking into consideration your education, training and experience?

If given training or the skills, what alternative occupation(s) are you interested in pursuing?

If given the opportunity to participate in rehabilitation aimed at safe return to an open market, would you be interested?

When do you expect to be able to take up occupation in future?

DD MM YYYY

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4. CLAIMANT HISTORY (CONTINUED):

MEDICAL HISTORY

Have you previously received any benefits from any other life insurance company? Yes No
If yes, please supply details:

When did you first notice your symptoms and when did it start to affect your ability to perform your job?

On what date did you first consult a Medical Examiner in connection with your condition? DD MM YYYY

In your own words, describe your medical condition, the cause, major complaints or problems and the treatment:

In your own words, describe your medical condition, the cause, major complaints or problems and the treatment:

Indicate any difficulties of daily living, for example washing, dressing, eating, mobility, toileting, self-care etc, that you are currently experiencing:

Indicate any difficulties of daily living, for example washing, dressing, eating, mobility, toileting, self-care etc, that you are currently experiencing:

How does this impairment limit you from performing any particular part of your main duties?

Have you been hospitalised due to your condition? Yes No
If yes, what is the name of the hospital?

Date of last admission DD MM YYYY

Date of last discharge DD MM YYYY

Please state dates, names and contact details of all Medical Examiners, Specialists, Hospitals or Clinics consulted in connection with your condition:
(Please provide hospital or clinic reference numbers)

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4. CLAIMANT HISTORY (CONTINUED):

MEDICAL HISTORY (CONTINUED)

Please state dates, names and contact details of all Medical Examiners, Specialists, Hospitals or Clinics consulted in connection with your condition:
(Please provide hospital or clinic reference numbers)

Have you suffered from any complications? Yes No
If yes, please supply details:

If your condition resulted from an accident, please give a brief description of the cirumstances surrounding the accident:

Date of the accident D D M M Y Y Y Y

Full name(s)

Police Station where the accident was reported

INCOME DETAILS

Have you instituted a similar claim with any other insurance company or through another employer? Yes No

Insurance company's name

Policy no

Are you receiving or do you expect to receive any income/funds during your disability? Yes No

Income would include funds from any employer, partner, assurance company, pension or retirement funds, life annuities or government source.

Source of benefit	Amount	Lump sum or monthly benefit payments	Benefit start date and end date

5. PAYMENT DETAILS:

To ensure fast payment and for your protection, payment will only be made by electronic funds transfer.
Payment will only be made to the policyholder or as instructed by the policyholder.
No payment to a third party will be allowed.

Name of account holder

Name of bank

Account no

Branch name

Branch no - -

Please ensure that the above information is correct. FedGroup Life will not be held responsible fro any delays or other damage due to incorrect details provided. We will require proof of the account (cancelled cheque or bank statement with the account number and name of the account holder) when payment is made directly to the claimant.

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6. DECLARATION BY CLAIMANT:

If a member's total lump sum disability cover (a combination of benefits from all companies) exceeds the maximum benefit allowable by ASISA, a member's disability benefits will be reduced proportianately by all insurers concerned.

A full disclosure of all monthly disability benefits is required. If the maximum income allowable has been reached, benefits will be aggregated in line with the allowable benefit.

Please give any additional information which may, in your opinion, influence your claim

In my capacity as the claimant, I declare and warrant that all statements and answers which may now or at the time be given in connection with this claim, whether in my handwriting or not, true and complete. I further understand that any incorrect statements or non-disclosure, which materially affects the assesment of this claim, will entitle FedGroup Life to declare this claim null and void.

The Claimant has the initial responsibility of providing medical and other documentary evidence of diability at his/her own cost. It is the insured's responsibility to prove that he/she is disabled in terms of the policy provisions.

I authorise any person, possessing of any information relating to illness or injury of the Claimant, to furnish FedGroup Life or its representatives with such information insofar as it may be necessary for FedGroup Life's consideration of this claim.

FedGroup Life is hereby authorised to make payment as instructed above and I acknowledge that payment, by FedGroup Life of the benefits claimed shall release FedGroup Life from all liability in respect of such benefits.

D D M M Y Y Y Y

Financial Planner's signature

Date

7. CONFIRMATION OF CLAIMANT DETAILS BY EMPLOYER:

PERSONAL DETAILS

Title

Surname

First name(s)

ID no

Income tax office

Income tax no

EMPLOYMENT DETAILS

Date Claimant commenced service with you

D D M M Y Y Y Y

Date Claimant joined the Policy

D D M M Y Y Y Y

Date on which you became aware that the Claimant might be disabled

D D M M Y Y Y Y

Have you submitted a Disability Benefit claim for this Claimant before?
If yes, please supply details:

Yes No

Initial

7. CONFIRMATIONOF CLAIMANT DETAILS BY EMPLOYER (CONTINUED):

EMPLOYMENT DETAILS (CONTINUED)

Did the Claimant work in a full time, permanent capacity for you on the last day at work? ☐ Yes ☐ No
If yes, please supply details:

Please indicate the Claimant's full employment history at his/her current employer, from the most recent to the earilest position:

	Most recent	Previous	Earliest
Date started			
Job title			
Education qualifications required for that position			
Experience required for that position			
Broad description of duties performed			
Date leaving			
Salary at the date of leaving			

Please specify the percentage of time spent on:

Managerial	%	Light manual	%	Machine operator	%
Admin / Clerical	%	Heavy manual	%	100%
Supervisory	%	Travel	%	
100%		100%		

Please advise which other alternative jobs within the company the Claimant would be capable of performing and are such jobs available?

WORK ENVIRONMENT

What percentage and hours per day does the Claimant work?

	Percentage	Hours
Indoors		
Outdoors		
At heights		

	Percentage	Hours
At depth		
Wet areas		
Dry areas		

How often is the Claimant exposed to the following conditions?

	Always	Sometimes	Seldom	Never	Hrs per day
Dust					
Vibration					
Noise					
Fumes					
Heat					
Cold					
Other:					

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7. CONFIRMATIONOF CLAIMANT DETAILS BY EMPLOYER (CONTINUED):

WORK ENVIRONMENT (CONTINUED)

Temperature range in place of work

Decible range in place of work

Type of dust and fumes

Please give any details of any safety hazards in the Claimant's job:

Please list all items, equipment, tools, materials and machinery used:

PHYSICAL REQUIREMENTS

How much time is spent on the following activities during a normal working day?	Always	Sometimes	Seldom	Never	Hrs per day	
Sitting						
Standing						
Walking on even terrain (specify kilometres)						
Walking on uneven terrain (specify kilometres)						
Kneeling						
Stooping						
Bending						
Crouching						
Squatting						
Climbing						
Use of both hands						
Use of fine co-ordination						
Vision						
Hearing						
Physical strength or power						
Reaching above shoulder						
Reaching below shoulder						

Does the Claimant's job involve any of the following?	Yes	No	How much	What
Lifting weights				
Pushing weights				
Carrying weights				
Pulling weights				

Only complete this section if driving is a component of the Claimant's job:

Licence codes required

Type of vehicles driven

Average distance driven km per day km per week km per month

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7. CONFIRMATIONOF CLAIMANT DETAILS BY EMPLOYER (CONTINUED):

PHYSICAL REQUIREMENTS (CONTINUED)

Only complete this section if flying is a component of the Claimant's job:

Type of aircraft flown:

Average distance flown ______ km per week Average number of hours flown ______ hrs per week

COGNITIVE REQUIREMENTS

How much time of the Claimant's job requires the following abilities during each working day?

	Always	Sometimes	Seldom	Never	Hrs per day
Numeracy					
Calculations					
Memory					
Concetration					
Decision making					
Problem solving					
Planning					
Judgement					
Insight					

COMMUNICATION REQUIREMENTS

Please indicate which of the following are inherent job requirements:

	Always	Sometimes
Verbal communication		
Written communication		
Electronic communication		
Telephonic communication		
Communication with clients		

	Always	Sometimes
Communication with collegues		
Reading		
Listening		
Conflict resolution		

Is the Claimant required to supervise staff? Yes No
If yes, how many?

Is the Claimant still performing his/her full time occupation? Yes No
If no, what aspect of his/her job is the Claimant currently unable to perform?

Please provide duties/tasks that the Claimant is currently performing, including hours worked and relevant remuneration thereof:

On which date was the Claimant last actively able to perform all duties of his/her occupation?

D D M M Y Y Y Y

Date on which the Claimant returned (if he/she has returned after disability)

D D M M Y Y Y Y

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7. CONFIRMATIONOF CLAIMANT DETAILS BY EMPLOYER (CONTINUED):

Days absent from work in the last two years (Please attach sick leave records and medical certificates)

Dates		Number of working days absent	Type of leave taken (annual, sick, unpaid etc)	Reason
From	To			

What attempts have been made to adapt the Claimant's work environment or duties to accomodate his/her impairments?

What efforts have been made to retain, skill, re-align and accomodate the Claimant in an alternative position?

Will you be willing to accomodate the Claimant in the future? Yes No

When do you expect the Claimant to resume his/her occupation?

On a part time basis: D D M M Y Y Y Y On a full time basis: D D M M Y Y Y Y

Gross pensionable monthly income on last day active at work? R

When did this salary become effective? D D M M Y Y Y Y

Average gross monthly income earned during the year before the Claimant's current condition (excluding overtime and any other non pensionable allowances) R

Did the Claimant's pensionable income fluctuate during the year prior to the commencement of his/her condition? Yes No
If yes, please supply details:

Has the Claimant suffered a loss of income since the onset of his/her condition? Yes No
If yes, please supply details:

Gross monthly income before the condition R

Gross monthly income since the start of the condition R

Are you aware of any other employer, insurance company, pension/provident fund, government source or any other source from which the Claimant may potentially receive any benefit for this period? Yes No

Source of benefit	Amount	Lump sum / monthly Benefit payments	Benefits start and end dates

Initial

8. DECLARATION BY EMPLOYER:

I declare that the answers and statements I have made are true and correct and I have not omitted or withheld any material fact from FedGroup Life. FedGroup Life is hereby authorised to make payment as instructed above and I acknowledge that payment, of the benefits claimed, shall release FedGroup Life from all liability in respect of such benefits.

I hereby warrant I have been duly authorised by the employer to sign this form on its behalf.

Name

Designation

D D M M Y Y Y Y

Employer's signature (duly authorised)

Date

9. CONTACT DETAILS:

On completion, please send this form to FedGroup Life

PO Box 782823
Sandton
2146

Tel: 011 305 2300
Fax: 011 305 2484
E-mail: grouprisk@fedgroup.co.za

Initial