DISABILITY CLAIM FORM – EMPLOYER

Please return to: Hollard Group Risk, 1st Floor, 34 Melrose Boulevard, Melrose Arch or Postnet Suite 196, Private Bag X1, Melrose Arch, 2076
Tel: (011) 351 5000. Email: hgrdisability@hollard.co.za

SECTION A: HOW TO CLAIM

Three forms are required for the submission of a disability claim.

1. DISABILITY CLAIM FORM – CLAIMANT (to be completed by the claimant)
2. DISABILITY CLAIM FORM – EMPLOYER (to be completed by the employer)
3. DISABILITY CLAIM FORM – MEDICAL ATTENDANT'S REPORT (to be completed by the claimant/employer and the medical attendant)

The claimant must obtain at his/her own expense, the medical attendant's report from a registered medical practitioner, who is not a member of the claimant's immediate family.

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

It is essential that both 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. If we ask for an original certified copy of a document we will not accept a certified copy of a previously certified copy.

This form is structured in eight sections:

- Section A: How to claim (informative section)

To be completed by either claimant or employer or both:

- Section B: Policy details
- Section C: Employer's details
- Section D: Claimant's personal details

To be completed by employer:

- Section E: Employer's report

To be completed by the employer:

- Section F: Occupational information
- Section G: Declaration

This fully completed form should be accompanied by the following supporting documentation:

- an original certified copy of the claimant's identity document
- a copy of the claimant's pay slip for the month of Disability
- a copy of the claimant's job description
- a copy of the claimant's sick leave records
- copies of any medical certificates on file with the employer

- proof of continuous premium payment during the waiting period
- proof of employer banking details (cancelled cheque or bank statement)
- accident report form from the South African Police Services (if applicable)
- accident report required by COID (if applicable)

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

PRIVACY

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 B: POLICY DETAILS

Employer:

Policyholder:

Policy number:

Membership / Employee number:

SECTION C: EMPLOYER'S DETAILS

Name of company:

Physical address:

Postal address:

Code:

Contact person:

Job title:

Telephone number:

Fax number:

E-mail address:

SECTION D: CLAIMANT'S PERSONAL DETAILS (to be completed by employer and claimant)

First names:

Surname:

Identity number:

Date of birth: DDMMYYYY

Gender: M F

Residential address:

Code:

Postal address:

Code:

Home telephone number:

Cell phone number:

Email address:

Occupation:

Tax Reference number:

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

1. When did the claimant join the company? DDMMYYYY

2. When did the claimant join the disability benefit scheme? DDMMYYYY

3. Is the claimant a full-time employee? Y N

4. Date appointed as full-time employee? DDMMYYYY

5. Month last risk premium was paid for? MMYYYY

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

7. What was the effective date of this salary? DDMMYYYY

8. Is the claimant still receiving a salary? Y N

If "Yes", what is the current salary amount?

If different from the salary declared in number 8, please advise from which date this new salary was applicable and reason for the difference?

Reason: Date: DDMMYYYY

Until what date do you intend to pay the claimant this salary? DDMMYYYY

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

10. Is the claimant still working? Y N

If "Yes", please provide details of current activities:

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

(a) Part-time basis? DDMMYYYY

(b) Full-time basis? DDMMYYYY

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

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

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

15. Have any steps been taken to assist the claimant to continue to work within the company? Y N

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): DDMMYYYY At (time): hhmm h

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

17. Please provide details of any benefit, salary or remuneration received by the claimant from whatever source (e.g. from you the employer, an insurance company, a fund or any other source).

Source of benefit	**Name of company and your reference number**	**Amount**
Monthly disability benefit		
Salary		
Commission		
Other employer earnings		

Pension		
COID/ WCA benefits		
Other insurance benefits		
Other source 1		
Other source 2		

SECTION F: OCCUPATIONAL INFORMATION (to be completed by the employer)

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

2. Is the claimant responsible for the supervision of any staff? Y N

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

3. Apart from the claimant's present occupation, please provide a brief job history, including previous positions held within the company.

From	To	Position held	Type of work done

4. Please provide details of formal training and any courses the claimant attended with the current employer.

From	To	College or institution	Nature of training	Grade/Standard achieved

5. Please select the job category that would be most applicable to the claimant's 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)

6. Please provide a brief summary of the claimant's main duties in -their role?

7. What is the minimum training /education required to perform the claimant's occupation?

School		Standard	
Technical		Diploma	
Professional		Degree	
On the job training		Months	

Other:

8. Please complete the questions below on the claimant's work environment.

8.1 Please describe the work conditions (e.g. metres, percentages, hours or actual descriptions):

Work Conditions	Yes	Details	Work Conditions	Yes	Details
Indoor			Outdoor		
Vibration			Noise		
Height			Depth		
Humid/Cold temperatures			Wet		
Rough Terrain			Smooth Terrain		
Underground			Fumes		
Balance Required			Dry		
Dust			Other		

8.2 Please provide the details of any known safety hazards in the claimant's occupational duties:

9. What are the daily standard working hours?

Week: Start time End time **Week-end:** Start time End time

10. Is shift work required? Y N

If "Yes", please provide details of alternate shift times:

11. Please complete the below on the physical demands of the claimant'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	☐	☐	☐	☐	☐

12. What hand tools, machines, materials and equipment are used to perform the claimant's occupational duties?

☐

☐

☐

13. Please describe the minimum mental abilities that a healthy individual requires to perform the claimant'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	☐	☐	☐	☐

14. Please describe the minimum communication skills required to perform the claimant'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	☐	☐	☐	☐

15. Only complete this question if driving is a component of the claimant's occupational duties.

Licence code(s) required: ☐

Type of vehicle(s) driven: ☐

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

16. Only complete this question if flying is a component of the claimant's occupational duties.

Type of aircraft flown: ☐

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

17. Only complete this question if diving is a component of the claimant's occupational duties.

Certification:

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

Are any mixed gasses used:

18. Only complete this question if mining is a component of the claimant's occupational duties.

Certification:

-Is the claimant involved with blasting or explosives? Y N

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

What type of mining is undertaken? Opencast Underground

If "Underground", please advise:

How often do they go underground:

Average number of hours spent underground per week:

What activities are performed whilst underground:

19. Only complete this question if going out to sea is a component of the claimant's occupational duties.

Seamen's licence:

How often: How long:

What activities are performed whilst out at sea:

SECTION G: 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 Life. In the event that this claim or any supporting claim documentation is found to be fraudulent or misrepresented, Hollard Life reserves the right to proceed with the appropriate action against the claimant.

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.

Signed at ____ on this ____ day of ____ 20____

Name of authorised signatory

Designation

Signature
For and on behalf of the employer

Company stamp

Identity Number of authorised signatory:

Telephone number of authorised signatory:

Email address of authorised signatory:

Signed at ____ on this ____ day of ____ 20____

Hollard is committed to "Creating and securing a better future" and therefore subscribes to an internal Anti-Fraud policy. Please report any suspicious or unethical activity anonymously on 0801 516 170 (toll free) or via email at Hollard@tip-offs.com.