



## DISABILITY CLAIM FORM – CLAIMANT

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 nine sections:**

- Section A: How to claim (informative section)

#### **To be completed by claimant:**

- Section B: Policy details
- Section C: Employer's details
- Section D: Claimant's personal details
- Section E: Claimant's report on Education and Training (to be completed by the claimant)
- Section F: Claimant's report on employment
- Section G: Claimant's report on claim
- Section H: Occupational information
- Section I: Declaration

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 or 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: CLAIMANTS REPORT ON EDUCATION AND TRAINING** (to be completed by claimant)

1. What was the highest level of education that you received?
2. Please give details of formal training, qualifications and any courses which you attended during your working career

From	Date To	Name of Employer, College or Institution	Qualifications obtained	Brief Description of Course content

**SECTION F: CLAIMANT'S REPORT ON EMPLOYMENT** (to be completed by the claimant)

1. What is your current position?
2. When did you start in your current position? DDMMYYYY
3. When were you last able to perform fully in your current position? DDMMYYYY
4. When did you stop working? DDMMYYYY
5. Are you still receiving a salary?
- If "No", when did you receive your last salary? DDMMYYYY
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


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

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


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

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

9. Apart from your current position, please supply a history of previous positions held with your current and previous employers.

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

**SECTION G: CLAIMANT’S REPORT ON CLAIM** (to be completed by the claimant)

1. What do you understand to be wrong with you?


2. When did you first experience symptoms relating to this condition? DDMMYYYY

Please describe these symptoms


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

**Nature of contributor**

**Details**

Accident (If “Yes”, please complete number 4 below)	<input type="text"/> Y <input type="text"/> N	<input type="text"/>
HIV:	<input type="text"/> Y <input type="text"/> N	<input type="text"/>
Previous illness or injury:	<input type="text"/> Y <input type="text"/> N	<input type="text"/>
Hazardous pursuit or pastime:	<input type="text"/> Y <input type="text"/> N	<input type="text"/>
Habits e.g. excessive alcohol consumption:	<input type="text"/> Y <input type="text"/> N	<input type="text"/>
Self-inflicted injuries	<input type="text"/> Y <input type="text"/> N	<input type="text"/>

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

The accident occurred at (place):

On (date): DDMMYYYY  At (time):hhmm h

The accident occurred at (place):

Name of Police Station where accident was reported

The SA Police case number:

Describe fully how the accident happened:


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

DDMMYYYY

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

6. Please provide details of the first medical practitioner consulted:

Name:

--

Telephone number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address:

--

	Code:				
--	-------	--	--	--	--

7. Name, address and telephone number of your usual family doctor:

Name:

--

Telephone number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address:

--

	Code:				
--	-------	--	--	--	--

8. Provide names, addresses and telephone numbers of all other medical practitioners including specialists consulted in connection with this condition.

Name:

--

Type of practice:

--

Address:

--

	Code:				
--	-------	--	--	--	--

Telephone number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Name:

--

Type of practice:

--

Address:

--

	Code:				
--	-------	--	--	--	--

Telephone number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Name:

--

Type of practice:

--

Address:

--

	Code:				
--	-------	--	--	--	--

Telephone number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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

Y  N

If "Yes", please provide details:


Y  N

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

If "Yes", please provide details:

Name	Type of Practice/ Specialty	From	To	Treatment & Outcome

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

Y  N

If "Yes", please provide details:

Date	Doctor/hospital	Investigation	Done	Outcome

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

Date	Therapy / Medication	Description / Dosage

(b) Is future surgery planned / required / anticipated?

Y  N

If "Yes", please advise when and provide description:


13. Has there been any improvement in your condition?

Y  N

If "Yes", please provide details.


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

Activity	Description	Can/With help/Cannot		
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	The ability to move indoors from room to room on level surfaces.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	The ability to move from a bed to an upright chair or wheelchair and <i>vice versa</i> .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	The ability to feed oneself once food has been prepared and made available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	The ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate. The maintenance of continence is included in this activity of daily living although it may be regarded as an activity of daily living on its own.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Please provide full details of your current daily activities.


16. Have you resided outside South Africa in the past year?

If "Yes", please provide details:

From	To	Country	Reason

17. Do you intend to reside outside South Africa?

If "Yes", please provide details:

From	To	Country	Reason

18. 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
Monthly disability benefit	<input type="text"/>	<input type="text"/>
Salary	<input type="text"/>	<input type="text"/>
Commission	<input type="text"/>	<input type="text"/>



Other employer earnings	<input type="text"/>	<input type="text"/>
Pension	<input type="text"/>	<input type="text"/>
COVID/ WCA benefits	<input type="text"/>	<input type="text"/>
Other insurance benefits	<input type="text"/>	<input type="text"/>
Other source 1	<input type="text"/>	<input type="text"/>
Other source 2	<input type="text"/>	<input type="text"/>

**SECTION H: OCCUPATIONAL INFORMATION** (to be completed by the claimant)

1. Please state your job title or position held?

2. Are you responsible for the supervision of any staff?  Y  N

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

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

From	To	Position held	Type of work done
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

From	To	College or institution	Nature of training	Grade/Standard achieved
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. 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)

  


6. Please provide a brief summary of your main duties in your role?

7. What is the minimum training /education required to perform your occupation?

School	<input type="text"/>	Standard	<input type="text"/>
Technical	<input type="text"/>	Diploma	<input type="text"/>
Professional	<input type="text"/>	Degree	<input type="text"/>
On the job training	<input type="text"/>	Months	<input type="text"/>

Other:

8. Please complete the questions below on your 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	<input type="checkbox"/>	<input type="text"/>	Outdoor	<input type="checkbox"/>	<input type="text"/>
Vibration	<input type="checkbox"/>	<input type="text"/>	Noise	<input type="checkbox"/>	<input type="text"/>
Height	<input type="checkbox"/>	<input type="text"/>	Depth	<input type="checkbox"/>	<input type="text"/>
Humid/Cold temperatures	<input type="checkbox"/>	<input type="text"/>	Wet	<input type="checkbox"/>	<input type="text"/>
Rough Terrain	<input type="checkbox"/>	<input type="text"/>	Smooth Terrain	<input type="checkbox"/>	<input type="text"/>
Underground	<input type="checkbox"/>	<input type="text"/>	Fumes	<input type="checkbox"/>	<input type="text"/>
Balance Required	<input type="checkbox"/>	<input type="text"/>	Dry	<input type="checkbox"/>	<input type="text"/>
Dust	<input type="checkbox"/>	<input type="text"/>	Other	<input type="checkbox"/>	<input type="text"/>

8.2 Please provide the details of any known safety hazards in your 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 your occupation:

Activity	Never	Sometimes	Often	Always	Hours per day
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking on even terrain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking on uneven terrain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of both hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Use of fine coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting weights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying weights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing weights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging in physical labour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working in cramped conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. What hand tools, machines, materials and equipment are used to perform your occupational duties?


13. Please describe the minimum mental abilities that a healthy individual requires to perform your occupational duties by completing the table below.

Abilities required	Very often	Often	Seldom	Examples of tasks requiring these abilities										
Literacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> </table>										
Numeracy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>											
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>											
Problem solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>											
Decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>											
Specialised knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>											
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>											
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>											
Calculations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>											
Administrative tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>											

14. Please describe the minimum communication skills required to perform your occupational duties by completing the table below.

Communication Skills required	Very often	Often	Seldom	Aspects of occupational duties requiring these communication skills					
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> </table>					
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Listening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Public speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

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

Certification:

Are you involved with blasting or explosives?

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

Y  N

What type of mining is undertaken?

Opencast       Underground

If "Underground", please advise:

How often do you 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 your occupational duties.

Seamen's licence:

How often:

How long:

What activities are performed whilst out at sea:

**SECTION I: DECLARATION** (to be signed and dated by claimant)

I,  hereby declare that I am the person insured under the policy mentioned above.

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. 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 Life reserves the right to proceed with the appropriate action against the claimant 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 Life:

- to obtain from any person, whom I hereby so authorise and request to give, any information which Hollard Life deems necessary, and
- 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

c) death) and in such detailed, abbreviated or coded form as may from time to time be decided by Hollard Life or by the operators of such data base.

I authorise any medical practitioner, hospital or other person to provide Hollard Life with any information Hollard Life may require relating to my medical history, my injury, my employment history and/or any other information which may be necessary for Hollard Life's consideration of the claim. I also provide consent that any information provided by me may be verified against other sources or data bases 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.

Signed at  on this  day of  20

Claimant's name

Signature

**In the event that the form was completed on behalf of the claimant:**

Caretaker's name

Signature

**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](mailto:Hollard@tip-offs.com).