DISABILITY CLAIM FORM

(To be completed by Life Insured)

Please note that it is essential to complete this form in full to prevent unnecessary delays as a result of missing information.

The following must be included when submitting this form:

a. A certified copy of the claimant's identity document (within 3 months)
b. Proof of bank account details of the claimant (e.g. copy of original bank statement within 3 months)
c. Proof of residence if address is not on the bank statement (within 3 months)

Return the completed form and the above documents to lifeclaims@hollard.co.za or fax to 086 659 0135.

If the policyholder is a Company, Close Corporation, Partnership, Sole Prop, Trust or Unincorporated Entity, please complete the FICA Form.

1. Life Insured details

Policy no. _____ Identity no. _____

Name of Life Insured _____

Date of birth D D M M Y Y Y Y Work tel. no. _____

Home tel. no _____ Cell no. _____

Email address _____ Mandatory

Physical address _____ Postal code _____

Postal address _____ Postal code _____

Country of residence _____

Employer's name _____

Occupation _____

2. Details of current employment

2.1 When did you start working for your current employer? D D M M Y Y Y Y

2.2 Were you working full-time for the above employer? YES ☐ NO ☐

2.3 What is your current position? _____

2.4 When did you start in your current position? D D M M Y Y Y Y

2.5 Provide a detailed description of your duties _____

_____

_____

2.6 Provide a summary of your duties _____

_____

_____

2.7 Does your work require any of the following (tick yes for all the functions that are applicable to your job and indicate the percentage of time allocated to these tasks) (must add up to a total of 100%)

Function	Yes	% time	Function	Yes	% time	Function	Yes	% time
Prolonged travelling	☐		Prolonged sitting	☐		Prolonged standing	☐	
Regular bending	☐		Climbing stairs	☐		Computing	☐	
Heights	☐		Carrying heavy objects	☐		Machine repair (office)	☐	
Large machine repair (industrial machinery and motors)	☐		Heavy manual labour (digging, loading)	☐		Light manual labour (physically packing, factory working, sorting)	☐	

2.8 Indicate which best describes your working conditions and where applicable provide details

Work conditions	Yes	Details	Work conditions	Yes	Details
Indoor	☐		Outdoor	☐	
Vibration	☐		Noise	☐	
Height	☐		Depth	☐	
Humid/cold temp	☐		Wet	☐	
Rough terrain	☐		Smooth terrain	☐	
Underground	☐		Fumes	☐	
Balance required	☐		Dry	☐	
Dust	☐		Other	☐	

Any other condition to be considered _____

2.9 When were you last able to perform fully in your current position?

D	D	M	M	Y	Y	Y	Y

2.10 When did you stop working?

D	D	M	M	Y	Y	Y	Y

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

Date		Details of employment			
From	To	Company	Position held	Type of work done (e.g. welding)	Reason for change

2.12 Have you been able to perform any part of your main duties or another job since you were unable to do your job in full? YES ☐ NO ☐

If YES, give details, including dates, job description and remuneration

_____

_____

_____

2.13 What was the highest level of education that you achieved? _____

2.14 Give details of formal training, qualifications and any courses that you have attended during your working career

Date		Name of employer, college or institution	Qualifications obtained	Brief description of course content
From	To			

2.15 When do you expect to be able to resume work?

Part-time basis D D M M Y Y Y Y Full-time basis D D M M Y Y Y Y

2.16 What was your total monthly income before you became disabled? R _____

2.17 Are you still receiving a salary? YES ☐ NO ☐ R _____

Full pay from: D D M M Y Y Y Y Full pay to: D D M M Y Y Y Y

Amount R _____

Reduced pay from: D D M M Y Y Y Y Reduced pay to: D D M M Y Y Y Y

Amount R _____

2.18 Give details of any benefit salary or remuneration that you have received or expect to receive as a result of your disability or during your disability, including details of salary, benefits from an insurance company, pension fund, state fund or any other source

Source of benefit (state name of company and your reference no.)	Type of beneift (e.g. insurance, lump sum)	Amount
		R
		R
		R
		R

2.19 Have you resided outside South Africa in the past year? YES ☐ NO ☐

If YES, provide details in the table below:

Date		Country	Reason
From	To		

3. Details of disability

3.1 What do you understand to be wrong with you? Please provide details in your own words.

3.2 When did you first experience symptoms relating to this disability?

D	D	M	M	Y	Y	Y	Y

Describe these symptoms

3.3 Has any of the following contributed in any way to your disablement?

Function	Yes	No	Details
Previous illness or injury	☐	☐	
Hazardous pursuit or pastime	☐	☐	
Habits, e.g. excessive alcohol consumption	☐	☐	
Self-inflicted injuries	☐	☐	

3.4 When did you first consult a medical practitioner in respect of your current disability?

D	D	M	M	Y	Y	Y	Y

3.5 Provide details of the doctor:

Practice no. _____

Tel. no. _____ Fax. no. _____

Address _____

Full name _____

Address _____ Postal code _____

3.6 Have you ever suffered from any other form of disablement or been declared disabled from employment before? YES ☐ NO ☐

Provide details _____

3.7 Details of your usual family doctor:

Name _____

Address _____ Postal code _____

Tel. no. _____ Fax. no. _____

3.8 Details of the doctor who is attending to your disability:

Name _____

Address _____ Postal code _____

Tel. no. _____ Fax. no. _____

3.9 Provide names, addresses and telephone numbers of all other medical practitioners including specialists consulted in connection with this disability

Name	Type of practice/speciality	Address	Telephone

3.10 Have you been referred to any health care professionals, e.g. physiotherapists, occupational therapists, psychologists, or other medical specialists? YES ☐ NO ☐

If YES, provide details below

Name	Type of practice/ speciality	From	To	Treatment	Outcome

3.11 Have you had any test, x-rays or special investigations relating to your disability or any other impairment? YES ☐ NO ☐

If YES, give details

Date	Doctor/Hospital	Investigation done	Outcome

3.12 a. How has your condition been treated?

Date	Therapy/Medication	Description/Dosage

b. Is future surgery planned/required/anticipated? YES ☐ NO ☐

If YES, advise when? D D M M Y Y Y Y

3.13 Has there been any improvement in your condition? YES ☐ NO ☐

If YES, give details _____

_____

_____

3.14 How has this disability affected your ability to perform your daily living activities?

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	☐ Can	☐ With help throughout	☐ Cannot
Mobility	The ability to move indoors from room to room on level surfaces and outdoors for 200 m on level surfaces	☐ Can	☐ With help throughout	☐ Cannot
Transferring	The ability to move from a bed to an upright chair or wheelchair and vice versa	☐ Can	☐ With help throughout	☐ Cannot
Dressing	The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances	☐ Can	☐ With help throughout	☐ Cannot
Feeding	The ability to cut food as well as to get food and/or drink to the mouth	☐ Can	☐ With help throughout	☐ Cannot
Toileting	The ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances, if appropriate. This includes the maintenance of continence	☐ Can	☐ With help throughout	☐ Cannot
Communicating	The ability to answer the telephone and take a message	☐ Can	☐ With help throughout	☐ Cannot
Reading	Having the eyesight required to be able to read a newspaper, book or magazine	☐ Can	☐ With help throughout	☐ Cannot
Bending and lifting	The ability to get into and out of a standard size car, bend, kneel or pick up something from the floor, lift, carry or move everyday objects	☐ Can	☐ With help throughout	☐ Cannot
Co-ordination	The ability to use hands and fingers with precision, including the ability to pick up and manipulate small objects, such as pens or cutlery	☐ Can	☐ With help throughout	☐ Cannot

3.15 Provide full details of your current daily activities _____

_____

_____

3.16 If this claim has arisen from an accident, please answer the questions below:

What was the date of the accident? | D | D | M | M | Y | Y | Y | Y |

How and where did the accident occur? _____

_____

_____

Police sation where the accident was reported _____ Case no. _____

4. Declaration

I declare that the statements above are true and complete. In the event that this claim or any supporting documentation is found to be fraudulent, Hollard Life reserves the right to proceed with the appropriate action against me.

I further authorise any medical attendant or any other person who has attended to the life insured, or any hospital or other institution that has medical information about the life insured, to disclose this information to Hollard Life.

All the particulars given are, to the best of my knowledge, true and complete and I have not omitted or withheld any relevant information. Accepting that I am hereby curtailing my right of privacy, but to facilitate the assessment of risk, and the consideration of any claim for benefits:

I irrevocably authorise Hollard Life:

a. to obtain from any person, who I hereby authorise to supply, any information which Hollard Life deems necessary, and
b. to share with other insurers that information and any information contained in this declaration or in any related policy or other document, either directly or through a database 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 Life or by the operations of such database.

Please take note of the following Hollard disclosures:

Protection of Personal Information Act (POPIA)

Hollard cares about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this form. We will treat this information with caution, and we have put reasonable security measures in place to protect it.

Financial Intelligence Centre Amendment Act (FICAA)

In accordance with applicable anti-money laundering laws in South Africa, we are required to obtain specific information and evidence to verify your identify (and in many cases the identities of related persons, such as but not limited to directors, beneficial owners and persons instructing us on your behalf (where applicable)) when applying for cover and on an on-going basis. If we ask you for information or documents (including originals or certified copies) you must provide them to us as soon as possible. If we do not receive adequate information and evidence within a reasonable time of our request, we may be unable to provide you with cover or may cancel the policy in accordance with applicable law.

Signature
(Life Insured) _____ **Date** | D | D | M | M | Y | Y | Y | Y |

Full name of witness _____

Tel. no. _____ Cell no. _____

Email address _____ Mandatory

Signature
(witness) _____ **Date** | D | D | M | M | Y | Y | Y | Y |