MyLife

Disability Claim Form - Claimant

Hollard. life

Please note that it is essential to complete this form in full to prevent unnecessary delays as a result of missing information.
Return the completed form and the above documents to LifeClaims2@hollardnam.com

Life assured details

Section 1

Full names	
Surname	
Previous surname	
Date of birth	Y Y Y Y M M D D — Nationality:
Identity number	
Passport number	Passport number not required if ID provided — Passport expiry date: Y Y Y Y M M D D
Occupation	
Employer	
Usual source of income	
Mobile number	
Residential address	
Email address	
Postal address	

Details of current employment

Section 2

Are you self-employed?	
If YES, since when?	Y Y Y Y M M D D
When did you start working for your current employer?	Y Y Y Y M M D D
Were you working full-time for the above employer?	Y N
What is your current position?	
When did you start in your current position?	Y Y Y Y M M D D
Provide a detailed description of your duties	

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%)

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

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

Indoor	Y		Rough terrain	Y	
Outdoor	Y		Smooth terrain	Y	
Vibration	Y		Underground	Y	
Noise	Y		Fumes	Y	
Height	Y		Balance required	Y	
Depth	Y		Dry	Y	
Humid/cold temp	Y		Dust	Y	
Wet	Y		Other	Y	

Any other condition to be considered

When were you last able to perform fully in your current position? Y Y Y Y M M D D

When did you stop working? Y Y Y Y M M D D

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	Reason for change

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? Y N

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

What was the highest level of education that you achieved?

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			

When do you expect to be able to resume work?

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

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

Are you still receiving a salary? Y N R

Full pay From: Y Y Y Y M M D D to Y Y Y Y M M D D

Amount R

Reduced pay From: Y Y Y Y M M D D to Y Y Y Y M M D D

Amount R

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 you reference no.)	Type of benefit (e.g. insurance, lump sum)	Amount
		R
		R
		R

Have you resided outside South Africa in the past year? Y N

Date		Country	Reason
From	To		

Details of disability

Section 3

What do you understand to be wrong with you? Give details in own words, refer to reports, is not acceptable.

When did you first experience symptoms relating to this disability? Y Y Y Y M M D D

Describe these symptoms

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

Previous illness or injury Y N

Hazardous pursuit or pastime Y N

Habits, e.g. excessive alcohol consumption Y N

Self-inflicted injuries Y N

When did you first consult a medical practitioner in respect of your current disability? Y Y Y Y M M D D

Provide details of the doctor

Practice no.

Full name

Tel. no. Fax. no.

Address

Have you ever suffered from any other form of disablement or been declared disabled from employment before? Y N

Provide details

Details of your usual family doctor

Full name

Tel. no. Fax. no.

Address

Details of the doctor who is attending to your disability

Full name

Tel. no. Fax. no.

Address

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

Have you been referred to any health care professionals, e.g. physiotherapists, occupational therapists, psychologists, or other medical specialists? Y N

If yes, provide details below

From	To	Name	Type of practice/speciality	Treatment	Outcome

Have you had any test, x-rays or special investigations relating to your disability or any other impairment? Y N

If yes, give details

Date	Doctor/Hospital	Investigation done	Outcome

How has your condition been treated?

Date	Therapy/Medication	Description/Dosage

Is future surgery planned/required/anticipated? Y N

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

Has there been any improvement in your condition? Y N

If yes, give details

How has this disability affected your ability to perform your daily living activities?		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	◯	◯	◯
Mobility	The ability to move indoors from room to room on level surfaces and outdoors for 200 m on level surfaces	◯	◯	◯
Transferring	The ability to move from a bed to an upright chair or wheelchair and vice versa	◯	◯	◯
Dressing	The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances	◯	◯	◯
Feeding	The ability to cut food as well as to get food and/or drink to the mouth	◯	◯	◯
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	◯	◯	◯
Communicating	The ability to answer the telephone and take a message	◯	◯	◯
Reading	Having the eyesight required to be able to read a newspaper, book or magazine	◯	◯	◯

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

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

How and where did the accident occur?

Police station where the accident was reported

Case no.

Declaration

Section 4

I declare that the above details are true and complete. I authorise any doctor or any other person who has attended to me or any hospital or other institution that has medical information about me, to disclose such 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.

Signature (claimant)

Date Y Y Y Y M M D D

Full name of witness

Tel. no. Cel. no.

E-mail address

Signature (witness)

Date Y Y Y Y M M D D

Identity Verification

(To be completed by Broker/Hollard representative)

Section 5

Life assured name

Life assured ID/Passport number

I, the undersigned, have identified the person named above to the best of my ability, for and on behalf of the Insurer, and have viewed and taken copies of authentic, reliable, independent source documents (as annexed hereto). By signature hereto, I do not bind myself and/or my employer to any liability arising from or attributable to this acknowledgement.

Name (Broker/Hollard Representitive):

Signature

Copy of ID (front and back) or Passport to be attached to this form