OLDMUTUAL CORPORATE

# GROUP ASSURANCE APPLICATION FOR **DISABILITY BENEFITS**

## GUIDELINES

**Please help Old Mutual Group Assurance to assess your claim correctly, and faster, by using these guidelines.**

1. Complete the application form in detail as it gives us important information.
2. Write your answers in clear black or blue block letters so that it is easy to read.
3. Use this checklist to ensure that you hand in all the necessary documents.

| **Checklist** | **Tick** |
|---|---|
| Employer section completed and signed | |
| Claimant section completed and signed | |
| Copy of the claimant's identification document | |
| Claimant's full job description or performance contract | |
| Comprehensive specialist report or completed medical questionnaire | |
| Sick leave records, with available reasons for absence | |
| Latest payslip with full salary | |
| For the commission earners: Salary records for the last 12 months | |
| Payment to Bank | |

Submit the claim electronically, by fax or post.

SOUTH AFRICA

Email newclaims@oldmutual.com

Fax 021 509 6855

Group Assurance: Disability Claims (6M)
Old Mutual
PO Box 1659
Cape Town 8000

You are welcome to contact us at telephone 021 509 3059 if you are unsure about any aspect of submitting a claim.

NAMIBIA

Email nam-gapnewclaims@oldmutual.com

Fax 061 299 3729

Employee Benefits:
Old Mutual
PO Box 25548
Windhoek

SUPERFUND

Email superfunddisabilityqueries@oldmutual.com

Fax 021 509 5770/1

Telephone 0860 20 30 40

Old Mutual SuperFund:
PO Box 728
Cape Town 8000

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# GROUP ASSURANCE APPLICATION FOR **DISABILITY BENEFITS**

**Please print in block letters using black or blue ink.**

## SECTION 1 TO BE COMPLETED BY THE EMPLOYER

### 1.1 CLAIM INFORMATION

Fund name

Scheme code

Employee's surname

Employee's first name(s)

Employee number

Employee tax number

Employment date D D M M Y Y Y Y

Date insurance cover began D D M M Y Y Y Y

Normal retirement age

### 1.2 EMPLOYER CONTACT DETAILS

Employer name

Physical address

Province

Postal address

Code Province

Name of contact person

Telephone code number

Cellphone

Email

Name of line manager

Telephone code number

### 1.3 EMPLOYEE INCOME INFORMATION

When was the person last at work? D D M M Y Y Y Y

On what basic annual income was the premium based at this date? R

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

What was the employee's basic annual income for the previous three years?

20____ , R

20____ , R

20____ , R

During which month is the annual salary increase granted?

Did the employee receive an increase after absence from work began? Yes No

If "Yes", when? D D M M Y Y Y Y

## 1.4 EMPLOYEE JOB DESCRIPTION

Job title

What are the main tasks that the employee must perform?

## 1.5 EMPLOYEE WORK PERFORMANCE

Is the employee currently on sick leave? Yes No

If "Yes", when did sick leave begin? D D M M Y Y Y Y

If "Yes", when is the employee expected back at work? D D M M Y Y Y Y

1.5.1 How did the employee perform *before* the onset of the health condition?

1.5.2 How did the employee perform *after* the onset of the condition? Alternatively, what prevents full productivity?

1.5.3 What accommodations have been made to remove obstacles to productivity, e.g. changes to the employee's duties, work hours, environment or equipment used?

If none are in place, state what accommodations are planned for the future.

## 1.6 OCCUPATIONAL INJURIES AND DISEASES

Has the employee been injured on duty or developed an occupational disease? Yes No

Does this claim relate to an accident? Yes No

If "Yes", please supply details of the injury, illness or accident.

Please note that the **Insured Claims** process is separate from the **Injury On Duty** process.

## 1.7 DECLARATION BY EMPLOYER

I declare that the above information is true and correct, and that no information has been withheld or omitted.

**Line Manager**

Name

Telephone code number

Fax code number

Signature Date D D M M Y Y Y Y

**Human Resource Consultant**

Name

Telephone code number

Fax code number

Signature Date D D M M Y Y Y Y

## SECTION 2 TO BE COMPLETED BY THE EMPLOYEE

### 2.1 PERSONAL INFORMATION

Surname

Name(s)

Identity number

Date of birth D D M M Y Y Y Y

Gender ☐ Female ☐ Male

Employee tax number

Physical address

Province

Postal address

Code Province

Telephone

Work code number

Home code number

Cellphone

Email

### 2.2 ALTERNATIVE CONTACT DETAILS (Please include the details of a family member, friend or colleague)

Surname

Name(s)

Relationship

Telephone code number

Cellphone

Email

### 2.3 AUTHORISATION

Accepting that I am thereby curtailing my right to privacy, but to facilitate the assessment and review of my disability claim under a group policy, I authorise Old Mutual

a) to obtain from any medical practitioner, health professional, hospital, employer, insurer or other person who may be in possession of, or later acquire, any information concerning my health, occupation and earnings at their request, and
b) to share this information with other parties, i.e. health professionals, the employer, fund or insurers for the sole purpose of the assessment or review of my disability claim.

I understand that Old Mutual needs this information to assess the validity of my disability claim.

Old Mutual will use your information or obtain information about you to verify your identity, for assessment of your disability claim, check claim/medical history on the ASISA Life and Claims register, fraud prevention and detection, market research and statistical analysis, audit and record keeping purposes, and compliance with legal and regulatory requirements.

You may access the personal information that we hold and request us to correct any errors or to delete this information. To view our full privacy notice, please visit our website on www.oldmutual.co.za.

Signature of employee

Date D D M M Y Y Y Y

Signature of witness

Name of witness

### 2.4 INSURANCE

Complete this question if you have other disability insurance cover.

Insurer

Policy number

## 2.5 EDUCATION AND TRAINING

| Qualification | Year |
|---|---|
| | |
| | |
| | |

## 2.6 WORK EXPERIENCE DURING THE PAST TEN YEARS

| Employer | Job title | Period | Reason for leaving |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## 2.7 WHAT OTHER JOBS COULD YOU DO WITH YOUR QUALIFICATIONS AND WORK EXPERIENCE?

## 2.8 HEALTH SERVICES

**Where do you go for healthcare? Please tick all the applicable options.**

☐ Private healthcare ☐ State hospitals and clinics ☐ Alternative medicine ☐ Traditional healer

Name of medical aid

Membership number

**Contact details of your doctor(s) or other health professionals**

| Name of doctor, therapist or clinic | Speciality | Telephone number | Patient number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Details about your health situation**

a) How does the condition affect your self-care (washing, dressing and eating); use of transport; ability to work and enjoy free time?

b) Describe your ability to walk, stand, sit, bend, lift and carry.

c) What is your greatest difficulty at present?

## 2.9 DECLARATION BY THE EMPLOYEE

I hereby declare that the above information is true and correct, and that no information has been withheld or omitted.

Signature of employee

Date D D M M Y Y Y Y

Signature of witness

Name of witness

OLDMUTUAL

Old Mutual is a Licensed Financial Services Provider

OLDMUTUAL CORPORATE

# GROUP ASSURANCE
# **PAYMENT** TO BANK

**Please print in block letters using black or blue ink.**

## FUND DETAILS

Name of fund

Fund code

## PAYEE'S DETAILS

Surname of payee

Initials

Identity number

## DETAILS OF ACCOUNT

Name of bank

Address

Branch

Branch code — Code at place where account is kept will be supplied by bank.

Account number

Type of account — ☐ Cheque ☐ Savings ☐ Transmission

**Please note that it is important that all details submitted on this form are correct as Old Mutual can accept no responsibility for any loss or damage arising out of the supply of incorrect details.**

Signature of employee

Date D D M M Y Y Y Y

Countersigned by bank

OFFICIAL STAMP OF BANK