momentum

Application for Disability Benefits

Statement by employee

Employee to complete this form

Note: A certified copy of your identity document should be attached to this form.
The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

Name of fund:

Name of company:

1. Particulars of employee

Member Title Initials

First name/s

Surname

Home language: Date of birth D D - M M - Y Y Y Y

RSA ID Yes No ID/Passport No.

Company employee no.: Gender: Male Female

Residential address:

Postal code:

Postal address:

Postal code:

Email

Tel No. (w) (h) (c)

Income tax office:

Income tax number:

Date last able to actively perform your own occupation: D D - M M - 2 0 Y Y

an alternative occupation: D D - M M - 2 0 Y Y

2. Details of occupation

1. (a) Date when you started working for your current employer: D D - M M - 2 0 Y Y

(b) Date when you started in your current occupation/position: D D - M M - 2 0 Y Y

2. Give a brief description of all the important activities of your current occupation/position.

(a) Job title

(b) Details of duties-list no more than FIVE key activities and give a brief description of each:

1.

2.

3.

2. Details of occupation (continued)

2. (c) Have you been able to perform part of your job, or another job, since your impairment? Yes No

(d) If you have performed another job, or if your job was changed, please give details of the job that you did, the date that it changed/started, and salary that you were paid.

3. Apart from your present occupation, please supply a brief job history, including previous positions held.

Dates				
From	To	Company	Position held	Type of work

3. Qualifications, training and experience

	Year	Standard/Qualification
Highest level of schooling:		
Technical qualifications (NTC, diplomas, etc.):		
Academic qualifications (e.g. degrees, etc.):		
Other training (e.g. certificates,in-house training, driver's licences & codes):		

Codes of driver's licences or any other licences that the claimant has: e.g. pilot's licence, engine driver, etc.:

4. Details of impairment

1. Please complete if your impairment arose from an accident or other violent means:

Date of accident: D D - M M - 2 0 Y Y

What type of accident/incident occurred?

Police station where reported:

Police case number:

Please complete if your impairment arose from illness or injury:

List of symptoms/complaints	Date first noticed
	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y

4. Details of impairment (continued)

2. How does the impairment affect you in doing your normal duties?

3a) Which duties can you no longer do?

3b) Which duties can you still do?

4. Please give the names of all doctors, specialists and hospitals you have consulted in connection with your impairment/disability.
Please state patient/hospital numbers where applicable.

Dates					
From	To	Hospital / Doctor	Address	Tel no.	Patient Number

5. Please give the name, address and telephone number of your regular family doctor/general practitioner:

Name

Address

Postal code:

Tel No.

6. If you have changed general practitioners in the last two years, please give details of all previous attending general practitioner/s:

7. Date that you first visited your current general practitioner: D D - M M - 2 0 Y Y

8. When was your last consultation? D D - M M - 2 0 Y Y

9. What alternative occupation(s) do you consider yourself suitable for and what training do you think would be needed for this/these occupations?

5. Personal details

1. Please indicate your hobbies and interests:

2. Please indicate how you generally spend your day since you have been suffering from the impairment:

06h00 - 07h00	
07h00 - 08h00	
08h00 - 09h00	
09h00 - 10h00	
10h00 - 11h00	
11h00 - 12h00	
12h00 - 13h00	
13h00 - 14h00	
14h00 - 15h00	
15h00 - 16h00	
16h00 - 17h00	
17h00 - 18h00	
18h00 - 19h00	
19h00 - 20h00	
20h00 - 21h00	
21h00 - 22h00	

3. Have you, in the last five years, suffered from any serious disease, illness or disablement? Yes ☐ No ☐

If yes, give details

4. Do you belong to a medical aid? Yes ☐ No ☐

If yes, give details

Name of scheme:

Membership no: When did you join? Give date: D D - M M - 2 0 Y Y

When will your membership stop/when do you expect it to stop?

6. Other compensation

1. Please list any other sources of compensation that you may receive as a result of your disability:

	Workmans compensation	Pension or Provident fund	Disability policies arranged by employer	Disability policies arranged by yourself
Estimated amount of benefit:				
How is benefit payable, e.g. monthly lump sum?				
Date benefit is, or becomes, payable:				
For how long is the benefit payable?				

2. Have you received any income since the date of disability? Yes ☐ No ☐

If yes, state:

Amount of income and date/s received	Source of income: – e.g. employer, insurance

7. Declaration

I, the undersigned,

identity number

confirm that I have submitted a disability claim against the (fund),

and declare that to the best of my knowledge, the particulars given above are true and complete. I further authorise any medical practitioner, hospital, my employer or any other person who may have information relating to my illness/injury, to provide Momentum (the "Insurer") with such information. I authorise the Insurer to disclose this information to any other party whose opinion is required for the assessment of the disability claim.

Signature of Member

D D - M M - 2 0 Y Y

Date

Signature of Witness

D D - M M - 2 0 Y Y

Date

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Application for Disability Benefits

Statement by Employer

Employer to complete this form

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

Fund name

Company name

1. Particulars of employee (Note - a copy of the claimant's last payslip must be attached)

Member Title Initials

First name/s

Surname

Date of birth D D - M M - Y Y Y Y Date joined current fund D D - M M - Y Y Y Y

Date joined company D D - M M - Y Y Y Y Date joined previous fund D D - M M - Y Y Y Y

Company/Employee reference no.:

Type of disability cover under the current fund:

Type of disability cover under the previous fund:

Present residential address (as per your record):

Postal code:

Annual income and its composition:

Last day actively able to perform own occupation D D - M M - 2 0 Y Y Last day physically at work D D - M M - 2 0 Y Y

Reason for submission of claim:

Contact person at company:

Direct tel no. of contact person at company:

Direct fax no. of contact person at company:

Email of contact person at company:

2. Details of occupation (Note - a job description must be attached)

2.1 (a) Occupation

(b) Details of duties. List FIVE main performance areas with a brief description of each:

1.

2.

3.

4.

5.

2. Details of occupation (continued)

2.2 Physical requirements: (Tick ☑the relevant column).

	Frequently	Sometimes	Seldom	Never
Sitting				
Walking				
Standing				
Climbing				
Crouching				
Carrying/lifting heavy (>30kg)				
Carrying/lifting medium (10-25kg)				
Carrying/lifting light (0-10kg)				

2.2.1 Activities: please complete the following table indicating the percentage of time spent on each activity during the working day if applicable. (The total should add up to 100%)

Activity	%	Activity	%	Activity	%
Communication		Calculating		Decision-making	
Reading		Memory		Specialised knowledge	
Writing		Problem-solving		Speaking	

2.2.2 What tools/equipment/machines are used to assist the employee to do this job? (e.g. trolleys, scaffolding, computers, etc?)

2.2.3 Normal working hours of job:

2.2.4 Describe the type of work environment in which the employee has worked, e.g. underground, dusty, noisy, etc.

2.3 Number of subordinates under employee:

2.4.1 Was the employee placed into another position or were any of the activities of his/her own occupation changed, prior to claiming for disability? Yes ☐ No ☐

2.4.2 If yes, please give a detailed description of changes to his/her normal occupation or other duties performed:

2.5 Apart from the employee's present job, please supply a brief job history, including previous positions held.

Dates			
From	To	Company	Position held	Type of work
D D - M M - 2 0 Y Y	D D - M M - 2 0 Y Y			
D D - M M - 2 0 Y Y	D D - M M - 2 0 Y Y			
D D - M M - 2 0 Y Y	D D - M M - 2 0 Y Y			

3. Qualifications, training and experience

	Year	Standard/Qualification
Schooling		
Technical		
Academic		
Other		

Codes of driver's licence or any other licences that the claimant has: e.g. pilot's licence, engine driver, etc:

4. Please provide details of the employee's sick leave record for the last two years, or attach computer printouts. Reasons for absence must be included.

Dates From	Dates To	Number of working days	Illness/Injury/Reason
DD - MM - 20YY	DD - MM - 20YY		
DD - MM - 20YY	DD - MM - 20YY		
DD - MM - 20YY	DD - MM - 20YY		
DD - MM - 20YY	DD - MM - 20YY		
DD - MM - 20YY	DD - MM - 20YY		
DD - MM - 20YY	DD - MM - 20YY		
DD - MM - 20YY	DD - MM - 20YY		
DD - MM - 20YY	DD - MM - 20YY		

5. Details of disablement

5.1 Describe the symptoms or signs that make it difficult for the employee to perform his/her normal work.

5.2 When did the illness first become evident or the injury occur?

5.3 Can the employee be placed in another occupation? Yes ☐ No ☐

If no, state why

5.4 Has the impairment/disability affected the employee's salary? Eg. When did he/she last receive a full salary? Has his/her salary been reduced? If so, from what date and by what amount?

6. Other compensation

1. Please list any other sources of compensation that you may receive as a result of your disability:

	Workmans compensation	Pension or Provident fund	Disability policies arranged by employer	Disability policies arranged by yourself
Estimated amount of benefit:				
How is benefit payable, e.g. monthly lump sum?				
Date benefit is, or becomes, payable:				
For how long is the benefit payable?				

7. Please supply a brief motivation from the employee's direct supervisor/manager concerning:

His/her attitude to work:

Specific problems noticed while performing his/her job:

His/her ability to communicate with other workers/clients:

Declaration

I declare that, to the best of my knowledge, the particulars given above are true and complete. I authorise Metropolitan to disclose this information to any other party whose opinion is required for the assessment of the disability claim.

Name

Official title:

Tel No.

Signature of Supervisor/Manager

D D - M M - 2 0 Y Y

Date

Employer's stamp

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Application for Disability Benefits

Statement by Attending Specialist

Attending specialist to complete this form

Note: Please attach copies of any recent test results and/or reports.

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

Claimant's name

Date of birth D D - M M - Y Y Y Y

The claimant has applied for an insurance benefit. To assess the applicant's state of health we require your assistance with the completion of the questions below. Unfortunately we are unable to begin the assessment of the disability claim until we receive this information.

1. The following proof of identity has been presented

RSA ID Yes No ID/Passport No.

2. Are you the applicant's attending specialist? Yes No

If yes, how long have you acted in this capacity?

Are you aware of the applicant having consulted any other medical person in the last two years and if so, who and when?

Medical Practitioner	Date	Reasaon
	D D - M M - 2 0 Y Y	
	D D - M M - 2 0 Y Y	
	D D - M M - 2 0 Y Y	

3. How frequently do you see the applicant?

When last did you see the applicant, excluding today? D D - M M - 2 0 Y Y

4. Please give details of the illness/accidents for which you have attended to since he/she was refered to you in the last two years?

5. When were you first consulted in connection with the current impairment? D D - M M - Y Y Y Y

6. In your opinion what was the last date that the applicant was last actively able to work? D D - M M - Y Y Y Y

7. Descibe in detail the nature and extent of the applicant's impairment

8. Give dates and outcome of any tests/investigations done to diagnose/quantify the appicant's condition and please enclose copies of any reports/ investigations done

9. Quantify fully the specific changes in function caused by the applicants impairment

(continued)

10. State whether any of the following contributed to the applicant's disablement

Previous illness/injury or personal habits	Yes	No
Wilful self-injury	Yes	No
War or civil commotion or any associated actions	Yes	No

If yes, give details

11. Please describe the previous and current treatment (including dosage and duration) that the applicant has received/is receiving for his/her impairment. Refer to medication, hospitalisation, counselling, physiotherapy, etc:

12. In your opinion is the treatment optimal and is the applicant compliant with the recommended treatment? Yes No

If no, suggest possible alternative therapy, medication, rehabilitation or surgery that may be attempted to maximise managment

13. Has the condition stabilised or regressed since onset?

14. Provide the short term and long term prognosis of the applicant with supporting reasons

15. In your experience, can you give an indication of the expected recovery period necessary for this applicant?

16. In your opinion is the condition one that will benefit from any form of active rehabilitation? Yes No

If yes, your suggestions would be appreciated

17.1 Please specify why, in your opinion, the applicant is finding it difficult to perform his/her current occupation and which specific functions of his/her occupation he/she cannot perform?

17.2 What functions can the applicant perform?

17.3 Your medical opinion on the applicant's ability to perform another occupation or his/her own occupation with reasonable accomodations

Doctors details:

D	R												
PRACTICE NO.													

Tel No:

Fax No:

Email:

Signature of Member

D	D	-	M	M	-	2	0	Y	Y

Date

Consent Form

I, the above signed, _____

authorise Momentum (the Insurer) to provide medical information that I have supplied to any other person who, in the opinion of the Insurer, is involved in the assessment of the Claimant's disability. I further authorise the insurer to use this information should it be required for legal proceedings.

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Application for Disability Benefits

Statement by Attending General Practitioner

General Practitioner to complete this form

Note: Please attach copies of any recent test results and/or reports.

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

Patients name

Date of birth D D - M M - Y Y Y Y

Your patient has applied for an insurance benefit. To assess the applicant's state of health we require your assistance with the completion of the questions below. Unfortunately we are unable to begin the assessment of the disability claim until we receive this information.

1. The following proof of identity has been presented

RSA ID Yes No ID/Passport No.

2. Are you the applicant's attending specialist? Yes No

If yes, how long have you acted in this capacity?

Are you aware of the applicant having consulted any other medical person in the last two years and if so, who and when?

Medical Practitioner	Date	Reasaon
	D D - M M - 2 0 Y Y	
	D D - M M - 2 0 Y Y	
	D D - M M - 2 0 Y Y	

3. How frequently do you see the applicant?

When last did you see the applicant, excluding today? D D - M M - 2 0 Y Y

4. Please give details of the illness/accidents for which you have attended to since he/she was refered to you?

5. When were you first consulted in connection with the current impairment? D D - M M - Y Y Y Y

6. In your opinion what was the last date that the applicant was last actively able to work? D D - M M - Y Y Y Y

7. Descibe in detail the nature and extent of the applicant's impairment

8. Give dates and outcome of any tests/investigations done to diagnose/quantify the appicant's condition and please enclose copies of any reports/ investigations done

9. Quantify fully the specific changes in function caused by the applicants impairment

(continued)

10. State whether any of the following contributed to the applicant's disablement

Previous illness/injury or personal habits	Yes	No
Wilful self-injury	Yes	No
War or civil commotion or any associated actions	Yes	No

If yes, give details

11. Please describe the previous and current treatment (including dosage and duration) that the apllicant has received/is receiving for his/her impairment. Refer to medication, hospitalisation, counselling, physiotherapy, etc:

12. In your opinion is the treatment optimal and is the applicant compliant with the recommended treatment? Yes No

If no, suggest possible alternative therapy, medication, rehabilitation or surgery that may be attempted to maximise managment

13. Has the condition stabilised or regressed since onset?

14. Provide the short term and long term prognosis of the applicant with supporting reasons

15. In your experience, can you give an indication of the expected recovery period necessary for this applicant?

16. In your opinion is the condition one that will benefit from any form of active rehabilitation? Yes No

If yes, your suggestions would be appreciated

17.1 Please specify why, in your opinion, the applicant is finding it difficult to perform his/her current occupation and which specific functions of his/her occupation he/she cannot perform?

17.2 What functions can the applicant perform?

17.3 Your medical opinion on the applicant's ability to perform another occupation or his/her own occupation with reasonable accomodations

To facilitate payment print your name and postal address below:

D R

PRACTICE NO.

Tel No:

Fax No:

Email:

Signature of Member

D D - M M - 2 0 Y Y

Date

Consent Form

I, the above signed,

authorise Momentum (the Insurer) to provide medical information that I have supplied to any other person who, in the opinion of the Insurer, is involved in the assessment of the Claimant's disability. I further authorise the insurer to use this information should it be required for legal proceedings.