



Claim for Spouse's Lump sum disability benefit

1 Contents

The following forms and documents must be completed and submitted with a claim for a disability benefit. **Sanlam will only assess the disability claim once in receipt of all the required documentation.**

- **Spouses Claim: Declaration by fund/scheme**
- **Statement by Spouse**
- **Confidential medical report:** *Report to be compiled by insured's treating specialist according to the guidelines attached. (See page 8).*

The following documents must also be submitted together with the claim forms to Sanlam.

- **Sick leave records:** *Provide copies of all sick leave records for the past 12 months.*
- **Salary statement:** *Please provide a copy of the insured's salary statement as on the date on which the spouse performed his/her duties. In the case of an insured who receives a commission based salary, we require the past 3 year's salary statements*
- **Identity document:** *Please provide a copy of the insured's and the spouse's identity documents*

2 General

- It is the spouse's responsibility to prove that he/she is disabled in terms of the policy provisions.
- The spouse has the initial responsibility of providing medical and other documentary evidence of disability at his/her own cost.
- The spouse is obliged to submit whatever medical or other information Sanlam may reasonably require.

3 Disclaimer

In line with the FIC Amendment Act, 2017 and other Party Due Diligence requirements, Sanlam has the obligation to identify and verify all persons or entities we interact with. Thus, please provide the information as requested in the forms.

Sanlam reserves the right to cancel the insurance immediately if any of the obligations in terms of the FIC Amendment Act, 2017 and other Party Due Diligence requirements are not met.

The employer must please either post, fax or e-mail the duly completed forms to:

Sanlam Corporate: Group Risk - Disability Claims (7709)
PO Box 1
Sanlamhof
Bellville
7532

Fax number (021)947-3207

E-mail address EBDisabilityClaimsBenefits@sanlam.co.za



Spouses claim: Declaration by fund/scheme

(Form to be completed by employer)

A Particulars of fund/scheme

Name of fund/scheme _____ Code _____

Name of branch/participating employer _____

E-mail address _____

Telephone number (____) _____

B Personal details of the insured

Full names and surname _____

Date of birth ____ / ____ / ____ (dd/mm/ccyy) Gender: Male Female

Marital status Single Married Divorced Co-habiting Widowed

Identity number _____

Particulars of membership

Membership no. _____ Pay-sheet no. (if any) _____

Date of entering service ____ / ____ / ____ Date of permanent appointment ____ / ____ / ____

Date of commencement of membership ____ / ____ / ____

If the scheme has been underwritten by Sanlam for less than one year, please complete the following:

Type of benefit and cover the insured enjoyed at the previous insurer.

Type of benefit _____ Cover amount R _____

Provide the date from when the insured was covered at the previous insurer? ____ / ____ / ____

Salary information for the past 3 years

Date of salary received (dd/mm/ccyy)	Annual salary (R)*	Annual cost to company salary (R)

* This must be the salary on which the premiums paid to Sanlam, are calculated.

Particulars of spouse

Surname _____

Full names _____

Previous name (if applicable) _____

Date of birth ____ / ____ / ____ (dd/mm/ccyy) Gender Male Female

Country of birth _____

Type of identification Identity document* Passport copy of applicable document compulsory

Number _____ Country of issue _____

Passport expiry date ____ / ____ / ____ (dd/mm/ccyy)

*Provide a copy of your Identification document or Identification Smart card (copies of both sides)

Country and/or Country of citizenship/Nationality RSA Other country Yes* No

* If "Yes", please give other country _____

Membership no. _____

Particulars of spouse *(continued)***Address and contact numbers**Residential address _____
_____ Postal/Zip code _____Postal address *(if it differ
from the residential address)* _____
_____ Postal/Zip code _____

e-mail address _____

Cell/Mobile _____ Other contact number (h) _____ (w) _____**Signed on behalf of the fund/scheme**, *(insured's manager, supervisor or any other person who is familiar with the circumstances).*

Initials and surname _____

Designation _____

Signature _____

Place _____

Date ____ / ____ / ____ *(dd/mm/ccyy)*



Statement by spouse for a disability claim (Form to be completed by spouse)

Particulars of spouse

Surname _____

Full names _____

Previous name (if applicable) _____

Date of birth ____ / ____ / ____ (dd/mm/ccyy) Gender Male Female

Country of birth _____

Type of identification Identity document* Passport *copy of applicable document compulsory*

Number _____ Country of issue _____

Passport expiry date ____ / ____ / ____ (dd/mm/ccyy)

*Provide a copy of your Identification document or Identification Smart card (copies of both sides)

Country and/or Country of citizenship/Nationality RSA Other country Yes* No

* If "Yes", please give other country _____

Address and contact numbers

Residential address _____

Postal/Zip code _____

Postal address (if it differ from the residential address) _____

Postal/Zip code _____

e-mail address _____

Cell/Mobile _____ Other contact number (h) _____ (w) _____

1(a) Educational History

Highest school qualification _____

Other training/qualifications _____

1(b) Occupational history

- Please give a detailed description of your career history, including your present occupation. The exact date(s) on which service commenced and was terminated, are required:

Name and address of employer	Period in service / From (dd/mm/ccyy)	Period in service/ To (dd/mm/ccyy)	Nature of work

- Please describe the most important functions of your occupation directly before disablement.

Full names and surname of spouse _____

1(b) Occupational history *(continued)*

- What illness, injury or impairment caused your inability to work?

- Please describe the symptoms you are experiencing and how it affects your ability to work.

- On what date did you last actively practice your occupation? _____ / _____ / _____ (dd/mm/ccyy)

- Have you been able to perform any other occupations or functions since you first became disabled?

- Based on your experience and training, what other occupations can you perform?

2 Nature of disability and medical care

- If your disability was caused by an accident, please give the following information:

- Circumstances causing the accident.

- If a formal enquiry was conducted, please state by whom and what the result was.

- Date of accident _____ / _____ / _____ (dd/mm/ccyy)

- Since what date did you experience the symptoms? _____ / _____ / _____ (dd/mm/ccyy)

- On what date did you see the doctor about this for the first time? _____ / _____ / _____ (dd/mm/ccyy)

- Provide the names and contact details of doctors/specialists/therapists consulted in this regard and provide details:

Name of doctor(s)/specialists/therapist consulted	Profession	Contact number(s)	e-mail address

- How do you spend your days?

- Which activities (not work related) can you not perform as a result of your illness, injury or impairment?

Full names and surname of spouse _____

3 Income

Are you receiving or do you expect to receive, any benefit, salary, pension or compensation of whatever nature as a result of or during your disability? (Including income from any employer, partner, assurance company, a pension or retirement annuity fund, any governmental fund or any other source.) Yes No

- If "Yes", please give the following details:

Regular amounts (Including Life annuities)

Source of benefit	Amount (R)	Commencement date of payment (dd/mm/ccyy)	Date of cessation (dd/mm/ccyy)

Disability amounts included in ordinary assurance at any other companies (Regardless of whether claim has been submitted already)

Name of company	Amount (R)	Date of payment (dd/mm/ccyy)

Tax particulars

Income tax reference number _____

Income tax office to which last return was rendered _____

4. Payment of benefits

Personal information

Name of account holder _____

Postal address _____
Postal code _____

Residential address _____
Postal code _____

E-mail address _____

Telephone number(s) (work) _____ (home) _____

If the benefits are to be paid into the insured's bank account, please provide us with a copy of a bank statement not older than three months as well as the following information:

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account Cheque/current Savings Transmission

I declare that I am the person described above and that the replies given to the questions and the statements made above are true and correct. Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks and the consideration of any claim for benefits under a policy related to this or any other proposal for insurance made by me, or in respect of me as insured, I irrevocably authorise Sanlam to:

Full names and surname of spouse _____

5 Disclaimer

In line with the FIC Amendment Act, 2017 and other Party Due Diligence requirements, Sanlam has the obligation to identify and verify all persons or entities we interact with. Thus, please provide the information as requested in the forms.

Sanlam reserves the right to cancel the insurance immediately if any of the obligations in terms of the FIC Amendment Act, 2017 and other Party Due Diligence requirements are not met.

6 Consent for Disclosure of Confidential Information and Declaration

I, _____ Identity number _____

hereby grant my voluntary and informed consent to medical practitioners to disclose my medical and personal records to the medical practitioners appointed by the insurer to assess my disability.

This includes my previous medical history as well as any psychological or psychiatric records for the purpose of determining my ability to perform my work.

I also declare that I have no objections to medical information being supplied to the medical advisor of Sanlam, the Reinsurers, and from and to the medical service providers involved in the disability assessment and rehabilitation processes for the consideration of any claim for benefits under a policy.

I also irrevocably authorise any doctor or other person who may be in possession of or who may later obtain possession of any information regarding my health, whether such information pertains to the past or to the future, to disclose such information to Sanlam and I agree that this authorisation will also remain in force even after my death.

I declare that I am the person described above and that the replies given to the questions are true and correct.

Full names and surname _____

Identity number: _____

Witness _____ Signature _____

Date _____ / _____ / _____ (dd/mm/ccyy) Place _____

Important: The examination and compiling of a medical report must be done by the patient's treating specialist and cannot be performed by a general practitioner.

Dear Doctor,

Sanlam is in the process of assessing the extent of the patient's disabilities, in view of a claim for disability benefits. To assist us in making a justified decision, we require a report regarding the functional impairment of the patient.

The assessment of a disability claim is based on the principals of **functional impairment** and **disability**. It is important that you are aware of our distinction between the two principles.

- **Functional impairment** is determined by using a medical diagnosis of the functions a person is able to perform and the functions that can no longer be performed.
- **Disability** is determined through a legal process that assesses the extent of a person's functional impairment, judged in conjunction with his/her job description, the policy conditions and personal factors such as education, experience, etc. (This decision will be made by Sanlam Life Insurance Ltd.)

Kindly supply Sanlam with a report, along the guidelines provided below, after you have examined and assessed the **functional impairment** of the patient.

Please note that the patient's identity needs to be established above doubt before proceeding with the examination. Confirm the document /means used to establish the patient's identity, in your report.

Any costs relating to this consultation and medical report, is for the patient's account. Should you require additional test / evaluations to establish the patient's functional impairment, the patient will also be responsible for settling these.

Guidelines for a medical report on functional impairment

- Diagnosis (DSM IV for psychiatric conditions)
- Date of onset and course of disease
- Severity Perpetual factors, secondary gain
- Current clinical findings. Detailed description
- Treatment
 - Treatment modalities
 - Types of medication and dosage
 - Duration of treatment
 - Therapeutic procedures
 - Rehabilitation
 - Hospitalisation
- Response to treatment
- Complications that are permanent
- Special investigations (e.g. ECG, X-rays, scans)
- Prognosis with optimal treatment
- Influence on lifestyle, activities of daily living and working capability
- Special requirements
 - Cardiovascular: NYHA classification, exercise capacity, stress ECG, ejection fraction, other
 - Respiratory: dyspnea-grading(ATS),exercise capacity,(METS or VO2 max.) vitalogram pre-and post-inhalation (3 attempts), chest X-ray, single-breath diffusion test (Dco) in cases of interstitial lung disease
 - Orthopaedic: X-ray and stress views, MRI or CAT scans, other (eg. nerve conduction tests)
 - Psychiatric: social functioning, concentration, psychometric tests in cases of cognitive impairment