



Declaration by Employer Claim for Disability

Please return the completed form to: **Living Benefit Claims**

Postal address PO Box 1, Sanlamhof 7532 Telephone number (021) 916-3455
e-mail address livingbenefits@sanlam.co.za Fax number (021) 947-5804

For Namibian policies refer to: claims.affluentsupport@sanlam.com.na or contact our Sanlam Namibia office at +264 61 294 7440.

Important:

An accurately completed form is essential in order to avoid delays in the assessment process. A claim can be considered only if all required documents and all the supplementary statements (as indicated below) have been completed in full and are in Sanlam Life's possession.

Please supply the following documents:

- Sick leave certificates - see page 3.
- Copy of Discharge certificate
- Non-generic job description.

Particulars of insured life

Plan number(s) _____

Surname _____

Full first names _____

Date of birth _____ (dd/mm/ccyy)

Identity number _____ (Compulsory)

Residential address _____ Postal code _____

Contact details: Telephone (home) () _____ Fax (home) () _____

Cell phone _____

e-mail address _____

Particulars of Employer

Full names and surname / Name of institution _____

Name of Group Scheme (only if applicable) _____

Employee reference number of claimant _____

Postal address _____ Postal code _____

Name of contact person _____

Contact numbers: Telephone () _____ Fax () _____

e-mail address _____

Plan number _____

General information

- Date of appointment _____ (dd/mm/ccyy)
- Name of occupation _____
- Date of appointment in this occupation _____ (dd/mm/ccyy)
- Define the essential functions of this occupation: **Please attach a non-generic job description.**

- Last date on which claimant was still actively able to perform his/her job. _____ (dd/mm/ccyy)
- Date of official discharge. _____ (dd/mm/ccyy)
- State the amount of hours the claimant engaged in the actions below. (Note: The hours must add up to the hours the client worked.) Please indicate the specific actions performed per hour.

Administrative duties	_____	_____
Manual / physical duties	_____	_____
Supervisory duties	_____	_____
Travelling by car, truck, etc.	_____	_____
Walking and standing	_____	_____
Total hours	_____	_____

- Please state the academic qualifications of the claimant. _____
- Gross average monthly salary before disability

Basic	R	_____
Overtime	R	_____
Other	R	_____
- Gross average monthly salary after disability

Basic	R	_____
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- Gross monthly pension after disability

R	_____
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Description of employee's disability (functional impairment)

- What is the cause of his/her disability?

- When did you first become aware of the condition? _____ (dd/mm/ccyy)
- Was the cause an injury sustained while on duty? Yes No

If "Yes", please provide us with the Injury sustained at work - report.

- Current work status (Please mark the applicable option)

Still at work	<input type="checkbox"/>
Working part-time	<input type="checkbox"/>
On sick-leave	<input type="checkbox"/>
Early retirement due to ill health	<input type="checkbox"/>
Working in alternative position	<input type="checkbox"/> If this option is selected, please answer the following questions:

- If the person was not considered for an alternative position, was it as a result of:
 - Lack of knowledge and/or experience? Yes No
 - Unable to engage emotional or physical? Yes No
- If the person accepted an alternative position, please answer the following questions:
 - Did the aspects mentioned below contribute to his/her appointment to the alternative position? Please provide reasons.

Training	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	_____
Experience	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	_____
Education	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	_____

Plan number _____

Description of employee's disability (functional impairment)

Alternative position (continue)

- Describe in full what his/her duties in the alternative position comprise and indicate exactly the nature of what he/she now does. (For example, it is not sufficient to say "He/she performs light clerical work" – please indicate the nature of the clerical work):

- State the amount of hours the client engaged in the actions below. (Note: The hours must add up to the hours the client worked.) Please indicate the specific actions performed per hour.

Administrative duties	_____	_____
Manual / physical duties	_____	_____
Supervisory duties	_____	_____
Travelling by car, truck, etc.	_____	_____
Walking and standing	_____	_____
Total hours	_____	_____

- Educational qualifications required for the alternative position:

- Gross earnings in the alternative position

Basic	R	_____
Overtime	R	_____
Other	R	_____

- Has he/she been appointed on a part-time or permanent basis? Part-time Permanent

- Does the employee have any promotion opportunities? Yes No

- Is the status of the alternative position higher than, equal to or lower than the position previously held?

- Please provide the reasons if an alternative position was offered, but the claimant did not accept the position.

Sick leave records

- Please provide us with a brief summary of all sick leave of longer than 2 days taken by the claimant during the past two years. Please include copies of the relevant doctor's certificates.

Illness or injury	Name of doctor(s) consulted	Dates from work		Total days absent
		From (dd/mm/ccyy)	To (dd/mm/ccyy)	

Plan number _____

Sick leave records (continue)

- Contact person with regard to sick leave records: _____
Contact number: Telephone () _____ Fax () _____
e-mail address _____

Declaration by Employer

I hereby declare that the information provided within is correct and no information was withheld.

Signature of authorised official _____

Name of authorised official _____

Capacity of authorised official _____

Date _____ (dd/mm/ccyy) Place _____

Official stamp of institution _____