NATIONAL BARGAINING COUNCIL
for the Hairdressing • Cosmetology • Beauty & Skincare Industry

## *HBSI PENSION FUND - FRONT OFFICE*

Postnet Suite 510
Private Bag X1
Die Wilgers
0041

Unit B3, Willow Office Park (Behind Toyota Dealer)
559 Farm Road (entrance in Simon VermootenRoad)
Die Wilgers, 0041

TEL: 086 1114 662 E-MAIL: hbsipension@prevue.co.za

Dear Sir / Madam

Please find attached the **Disability** Claim Form (Verso) and the **Hollard** Disability claim forms for your attention. All Claim Forms must be **signed** by the **last Employer** as well as you, the **Employee.**

Verso Fund Administration Form -Benefit claim form

Hollard Form 1 : Disability claim form – Medical attendant's report

Hollard Form 2 : Disability claim form – Claimant & employer

Please attach the following to the completed forms:

1. **Certified** copy of your Identity Document. Not older than 3 months.
2. Copy of your Marriage Certificate (If applicable).
3. A copy of the Divorce order(If applicable)
4. Proof of Bank Details (in member's name) Not older than 3 months.
5. Proof of residential address.
6. **NB! Proof** of your personal income tax number. (If you don't have an income tax number, please contact SARS on 0800 007277.)
7. Copy of your most recent payslip.

The **Hollard** claim forms must be complete in full.

**NB:** **All** available clinical evidence/medical reports relevant to the claim.

You can email the completed claim forms with all required documents to hbsipension@prevue.co.za

Please make sure the pages are clear and readable.

**(No Pictures or Links will be allowed, only scanned PDF documents)**

If you have any questions, please contact us.

Kind regards,

**National HBSI Pension Fund**

**Tel no: +27 86 111 4662**

**Cell : +27 72 858 9786**

**Email : hbsipension@prevue.co.za**

VERSO FINANCIAL SERVICES (PTY) LTD
An authorised Financial Services Provider

Belmont Office Park, Twist Street, Bellville, 7530
P.O. Box 4300, Tyger Valley, 7536
Tel: 021 943 5300
Fax: 021 917 4601
E-mail: info@verso.co.za
Web: www.verso.co.za

# BENEFIT CLAIM FORM

FUND NAME _____

## TO BE COMPLETED BY THE MEMBER

### MEMBER DETAILS

MEMBER NO. _____ EMPLOYEE NO. _____

SURNAME _____ FIRST NAMES _____

DATE OF BIRTH _____ IDENTITY NUMBER _____

GENDER: MALE ☐ FEMALE ☐ MARITAL STATUS _____

RESIDENTIAL ADDRESS _____

_____

POSTAL ADDRESS _____

_____

*(Both of the above addresses are required by the SA Revenue Services - SARS)*

TEL NO. (_____)_____ CELL PHONE NO. _____

E-MAIL ADDRESS _____

PREFERRED LANGUAGE FOR CORRESPONDENCE: ☐ ENGLISH ☐ AFRIKAANS

INCOME TAX REFERENCE NO. _____ REVENUE OFFICE OF LAST TAX RETURN _____

### BANKING DETAILS

*(Please attach a copy of your bank statement)*

ACCOUNT HOLDER'S NAME _____

BANK NAME _____ ACCOUNT NUMBER _____

BRANCH NAME _____ BRANCH CODE _____

ACCOUNT TYPE: ☐ CURRENT ☐ SAVINGS ☐ TRANSMISSION

FOREIGN ACCOUNT ☐ (Tick if applicable) COUNTRY _____

### DIVORCE ORDERS

Are you aware of any Divorce Order issued by the High Court / Supreme Court against your pension benefit in favour of an ex-spouse?

☐ YES ☐ NO

If yes, attach an original certified copy of the complete divorce court order to this form (if not already supplied to the Fund). This order must be in terms of Section 7(8) of the Divorce Amendment Act 1989, to be binding on the Fund. Please provide full contact details of the ex-spouse in order for the benefit payment to be made by the Fund.

## Ex-spouse Details

SURNAME _____ FIRST NAMES _____

DATE OF BIRTH _____ IDENTITY NUMBER _____

RESIDENTIAL ADDRESS _____

_____

POSTAL ADDRESS _____

_____

TEL NO. (_____)_____ CELL PHONE NO. _____

E-MAIL ADDRESS _____

## BENEFIT OPTIONS (Withdrawal and Retirement Claims ONLY)

*Please refer to the **IMPORTANT NOTES** section below, before exercising an option*

☐ Leave my benefit invested in the Fund until further notice (if applicable in terms of the Rules of the fund, please refer to your Human Resources office).

☐ Pay benefit directly into my own bank account as specified above.

☐ Pay portion of my benefit into my own account as specified above. Specify amount or percentage: _____

***On retirement from a Pension Fund you are entitled to commute up to a maximum of 1/3rd (33.33%) of your retirement benefit. The exception to this rule is if your retirement benefit is less than R247 500, you are then permitted to take the full retirement benefit as a lump sum.***

☐ Transfer of Benefit; ☐ Full Benefit

☐ Portion of Benefit: Specify amount or percentage: _____

NAME OF FUND: _____

TYPE OF FUND: _____

CONTACT DETAILS: _____

## IMPORTANT NOTES

**Paid -up Membership**

1. **Terms**

   As a paid-up member, you are required to preserve your entire withdrawal benefit in the Fund (i.e. you may not take any portion in cash and preserve the balance). You may access your paid-up benefit (cash and/ or transfer) at any age prior to or at retirement. No new contributions to the Fund are permitted. No deductions may be made from your member share in respect of any insured risk benefits.

   With effect from 1 March 2019, you automatically become a paid-up member in the Fund on the termination of your employment, if you ***do not choose a benefit option***. You remain a paid-up member in the Fund until you complete and submit a withdrawal claim form, instructing the Fund what you wish to do with your member share.

2. **Tax**

   You do not pay any tax when you become a paid-up member. Any future lump sum taken will be taxed on the same basis as any other lump sum payment from a fund.

3. **Investments**

   Your member share remains invested in your elected investment portfolio. You are permitted 1 free switch per year and the cost for additional switches is R350 (including VAT) per switch and will be paid from your member share. For more detail about the investment options, fees or the underlying investment portfolios, please contact the Fund's Administrator on 021 943-5330 or 021 943-5357 or send your ID number and contact number to rbc@verso.co.za and a counsellor will contact you.

4. **Communication**

   You will receive an annual benefit statement (including a confidential beneficiary nomination form), as well as a Paid-up certificate, confirming your status as a Paid-up member.

5. **Fees**

   For information on the fees payable for Paid-up membership, please contact the Fund's Administrator on 021 943-5330 or 021 943-5357 or send your ID number and contact number to rbc@verso.co.za and a counsellor will contact you.

**Retirement Benefits Counselling**

You have access to Retirement Benefits Counselling prior to you deciding on the payment of your Fund benefit and before your benefit is paid to you or is transferred to another approved fund. The option(s) you exercise now may have a long-term impact on your financial well-being and you are encouraged to take the necessary steps to empower yourself to make well-informed decisions. Please contact the Fund's Administrator on 021 943 5330 or 021 943 5357, if you wish to speak to a counsellor. Alternatively, you can send your contact number and ID number via e-mail to rbc@verso.co.za and a counsellor will contact you.

**Deductions to be made from pension benefits**

Any legitimate deductions will be made from your benefit irrespective of your option chosen. This is particularly relevant if you have an outstanding pension backed housing loan balance at the time of your exit from employment.

**Financial Advice**

The Fund encourages members to constantly seek financial advice on all fund matters and particularly when benefits become payable. Please note that the Fund will not pay fees or commissions to any financial advisers.

**Confidentiality**

The information disclosed within this document will be treated as confidential and will only be used for the purpose for which it is intended in terms of applicable legislation.

**Tax Directive**

Payment will only be made on receipt of a tax directive, issued by the SA Revenue Service (SARS).

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## DECLARATION BY MEMBER

It is hereby confirmed that:

1. The information contained herein is correct.
2. I am satisfied with the information and / or counselling that I received and the benefit options available to me were disclosed and explained in a clear and understandable language.

SIGNATURE OF MEMBER _____ DATE _____

## TO BE COMPLETED BY THE EMPLOYER

## EMPLOYER DETAILS

NAME OF EMPLOYER _____

TEL NO. (_____)_____ CELL PHONE NO. _____

E-MAIL ADDRESS _____

## BANKING DETAILS

ACCOUNT HOLDER'S NAME _____

BANK NAME _____ ACCOUNT NUMBER _____

BRANCH NAME _____ BRANCH CODE _____

ACCOUNT TYPE: ☐ CURRENT ☐ SAVINGS ☐ TRANSMISSION

REFERENCE NUMBER _____ (if applicable)

## CLAIM DETAILS

DATE OF TERMINATION OF SERVICE _____

REASON FOR TERMINATION OF SERVICE:

☐ WITHDRAWAL _____ (Resignation, Dismissal, Abscondment, Retrenchment, Transfer)

☐ RETIREMENT _____ (Voluntary Early, Compulsory Early, Normal, Late, Ill-health)

☐ DEATH

**CONTRIBUTION DETAILS**

FINAL MONTH IN WHICH CONTRIBUTION WAS MADE _____

AMOUNT OF FINAL CONTRIBUTION R_____ MEMBER

R_____ EMPLOYER

**PRIOR CLAIM**

Is there a prior claim in respect of section 37D of the Pension Funds Act? ☐ YES ☐ NO
*If yes, please provide proof of the claim and employer banking details.*

| | |
|---|---|
| Housing loan guarantee by the fund to the bank (Fund's home loan facility): | R |
| Compensation for damage caused by the employee*: | R |

*Where "Compensation for damage caused by the employee" applies, the employee and employer are required to complete the 'Acknowledgement of Liability and Agreement to Pay' form which is available for download from the website.

## DECLARATION BY EMPLOYER

It is hereby confirmed and warranted:

- The employer has made every reasonable effort to inform the member that the Fund has a mandatory obligation to provide access to Retirement Benefits Counselling, before the member makes any decision regarding the options available, at termination.
- The information contained herein is correct and in particular, that the banking details provided above have been confirmed as correct;
- The employer will endeavor to take reasonable steps to ensure that the member exercises a benefit option and signs the form;
- The employer acknowledges that, where the member does not exercise a benefit option and / or sign the form, the member will automatically become a paid-up member in the fund three months after the Administrator has been informed that the member's employment was terminated.

The Employer hereby unconditionally absolves the Fund and Verso Financial Services and as necessary keeps indemnified the Fund and Verso Financial Services from and against all and any loss, damage, costs and expenses which the member, beneficiaries or any other person whatsoever, may sustain or incur, either directly or indirectly as a result of Verso Financial Services, on behalf of the Fund, relying on and using any information supplied by the Employer.

FULL NAME OF AUTHORISED OFFICIAL OF THE EMPLOYER _____

WORK TEL NO. (_____)_____ FACSIMILE NO. (_____)_____

E-MAIL ADDRESS _____

SIGNATURE OF AUTHORISED OFFICIAL OF THE EMPLOYER _____

DATE _____ EMPLOYER STAMP

## SUPPORTING DOCUMENTS REQUIRED

WITHDRAWAL: Bank Statement

RETIREMENT: Proof of identity
Bank Statement

DEATH: Original certified copies of the following documents:

- Death Certificate (BI-5 or BI-20)
- Member and Spouse's Identity document
- Marriage Certificate
- Identity documents of any other dependants
- Beneficiary Nomination Form

Disposal of Death Benefits Form
Banking Details and Addresses of Dependants/Beneficiaries

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## DECLARATION

The information disclosed within this document will be treated as confidential and will only be used for the purpose for which it is intended in terms of applicable legislation. Verso Financial Services is committed to protecting and promoting the privacy of personal information of all data subjects as required by the Act; to give effect to the constitutional right to privacy; and to fulfill its obligations under the Act. As the privacy of our clients is important to us, we will use reasonable efforts to ensure that any personal information, (including special personal information), provided to us is processed in a secure manner. Verso Financial Services takes its responsibility seriously in respect of securing the integrity and confidentiality of all personal information in its possession or under its control and has taken appropriate and reasonable technical and organisational measures to prevent – loss of, damage to or unauthorised destruction of personal information; and unlawful collection, access to or processing of personal information. Please go to www.verso.co.za to view our privacy policy statement.

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Hollard Group Risk

# DISABILITY CLAIM FORM – MEDICAL ATTENDANT'S REPORT

Please return to: Hollard Group Risk, 22 Oxford Road, Parktown, or PO Box 87428, Houghton 2041. Tel: (011) 351 5000, Fax: (011) 351 3079, email: hgrdisability@hollard.co.za

## SECTION A: HOW TO CLAIM

The claimant must obtain at his/her own expense, the medical attendant's report from a registered medical practitioner, who is not a member of the claimant's immediate family.

The medical attendant must complete this form to ascertain the diagnosis, changes in functional capacity due to illness or injury, optimal medical treatment and to assess the claimant's degree of medical impairment.

It is essential that this form is fully completed to prevent any unnecessary delays due to missing or incomplete information. This form may be submitted to Hollard Life by the employer, claimant or the medical attendant.

This form is structured in six sections:

- Section A: How to claim (informative section)
- Section B: Scheme details (to be completed by employer or claimant)
- Section C: Claimant's personal details (to be completed by employer or claimant)
- Section D: Medical attendant's details (to be completed by the medical attendant)
- Section E: Medical information (to be completed by the medical attendant)
- Section F: Declaration (to be signed by the medical attendant)

This fully completed form should be accompanied by the following supporting documentation:

- copies of any reports (e.g. EEG, X-rays, previous consultations, etc.)
- copies of any laboratory results (e.g. histology, blood results (including CD4 counts), etc.)
- copies of any additional information to substantiate the claim

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Life.

## SECTION B: SCHEME DETAILS (to be completed by employer or claimant)

Employer:

Policyholder:

Policy number:

Membership / Employee number:

## SECTION C: CLAIMANT'S PERSONAL DETAILS (to be completed by employer or claimant)

First names:

Surname:

Identity number:

Date of birth: D D M M Y Y Y Y Gender: M F

Residential address:

Code:

Postal address:

Code:

Home telephone number:

Cellphone number:

E-mail address:

**SECTION D: MEDICAL ATTENDANT'S DETAILS** (to be completed by medical attendant)

Title: First names:

Surname:

Qualification: Practice No:

Physical address:

Code:

Postal address:

Code:

Telephone number:

Fax number:

E-mail address:

**SECTION E: MEDICAL INFORMATION** (to be completed by medical attendant)

1. What is the diagnosis of the claimant's condition?

2. Date of diagnosis of the claimant's condition: D D M M Y Y Y Y

3. Date of the first consultation? D D M M Y Y Y Y

4. Date of the last consultation? D D M M Y Y Y Y

5. What is the claimant's height (cm) and weight (kg)

6. When did the first symptoms of the condition claimed for appear? D D M M Y Y Y Y

7. What is the cause of the claimant's condition?

8. What are the resultant limitations experienced by the claimant?

9. Please provide details of any complications or concurrent conditions:

10. Are you still attending to the claimant? Y N

11. Does the claimant have insight into his/her condition? Y N

If "No", please provide details:

12. Please provide details of all consultations in the last five years:

| Date | Reason for consultation | Diagnosis | Treatment | Outcome |
|---|---|---|---|---|
| | | | | |
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13. Has the claimant ever been hospitalised for this or any other conditions? Y N

If "Yes", please provide details of hospitalisation:

| Date admitted | Date discharged | Reason | Name of hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please provide details of the treatment received during the hospitalisations mentioned above.

| Name of hospital | Treatment | Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

14. Has the claimant had any special investigations? E.g. X-ray, EEG, tests. Y N

If "Yes", please provide details:

| Date | Special investigation | Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

15. Has the claimant been referred to any other health care professionals e.g. Physiotherapist, Occupational Therapist, Psychologists or other medical specialists? Y N

If "Yes", please provide details:

| Name | Type of Practice/ Specialty | From | To | Treatment | Outcome |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

16. Have any of the following contributed in any way to the claimant's condition?

| Nature of contributor | | | Details |
|---|---|---|---|
| HIV (If "Yes", please supply the CD4 count) | Y | N | |
| Accident | Y | N | |
| 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 | |

17. How has the claimant's condition been treated?

| Date | Therapy / Medication | Description / Dosage |
|---|---|---|
| | | |
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| | | |

Please provide more details on treatment by completing the table below:

| Aspect | | | Details |
|---|---|---|---|
| Strict compliance by claimant with medication / therapy? | Y | N | |
| Is condition satisfactorily controlled? | Y | N | |
| Is claimant undergoing optimal therapy? | Y | N | |
| Is future surgery planned / required / anticipated? | Y | N | |

If "Yes" please advise when?

Any additional comments:

18. Please provide an indication of the short-term prognosis with reasons:

19. Please provide an indication of the long-term prognosis with reasons:

20. Please complete the assessment scale below to describe the nature of the claimant's impairment in relation to the following activities of daily work. Please complete section 20.1 and either section 20.2 or section 20.3. Please tick only the most appropriate response.

**20.1 This section must be completed in all instances.**

**20.1.1. Sensory Motor Abilities**

**(a) Vision and hearing**

☐ The claimant's vision and/or hearing abilities, with the use of assistive devices, are not reduced to the extent that physical assistance from another person is required.

**OR**

☐ The claimant's vision and/or hearing abilities are reduced to the extent that functional abilities are affected and independent functioning without physical assistance from another person in a workplace is impossible, even with the use of assistive devices.

**OR**

☐ The claimant is entirely functionally blind or deaf.

**(b) Speech**

☐ The claimant's speech abilities, with the use of assistive devices, are not reduced to the extent that physical assistance is required.

**OR**

☐ The claimant's speech abilities are reduced to the extent that verbal communication within a workplace requires physical assistance, both through another person and an assistive device.

**OR**

☐ The claimant is entirely unable to verbally communicate within a workplace, despite physical assistance through another person and an assistive device.

**20.1.2. Mobility within the workplace**

☐ The claimant is able to move independently between essential workstations with, at the most, the assistance of a walking cane or other assistive device (including a wheelchair).

**OR**

☐ The claimant requires partial physical assistance, from another person, even with the use of support apparatus and a walking cane or other assistive device (including a wheelchair), in order to move between essential work stations.

**OR**

☐ The claimant requires constant physical assistance, from another person, for mobility between essential workstations, despite the workplace meeting the legislative requirements for accessibility.

**20.1.3. Cognitive impairment**

☐ The claimant's cognitive ability is unimpaired regardless of any presence of irreversible cognitive deterioration or damage that is organic in nature.

**OR**

☐ The claimant medically requires periodic assistance or direct supervision to perform work tasks, due to deterioration in or damage to cognitive ability, as measured by clinical evidence and standardised tests, that is irreversible and organic in origin.

**OR**

☐ The claimant medically requires constant assistance to perform work tasks, due to deterioration in or damage to cognitive ability, as measured by clinical evidence and standardised tests, that is irreversible and organic in origin.

**OR**

☐ The claimant is totally unable to perform work tasks despite constant assistance, due to cognitive deterioration or damage, as measured by clinical evidence and standardised tests, that is irreversible and organic in origin.

**20.2 Professional / White collar activities of daily work (if applicable).**

**20.2.1. Work stamina**

☐ The claimant is able to meet the full (i.e. 75% to 100%) effort tolerance and endurance requirements, with regular breaks.

**OR**

☐ The claimant is able to meet 40% to 75% requirements for effort tolerance and endurance, with prolonged rest periods, the use of good ergonomic principles and assistive devices or support system.

**OR**

☐ The claimant is able to meet at most 40% requirements for effort tolerance and endurance, despite prolonged rest periods, the use of good ergonomic principles and assistive devices or support system.

**20.2.2. Co-ordination and dexterity**

☐ The claimant is able to use both upper limbs in a coordinated and dexterous manner in order to perform gross and fine motor work activities.

**OR**

☐ The claimant is able to perform gross motor work activities, albeit in an awkward fashion, but requires physical assistance from another person to perform fine motor work activities, despite appropriate adaptations and assistive devices.

**OR**

☐ The claimant is unable to perform gross and fine motor work activities despite appropriate adaptations, the use of assistive devices and physical assistance from another person.

**20.3 Manual / Blue collar activities of daily work (if applicable)**

**20.3.1. Physical capabilities**

**(a) Dynamic work postures. These are defined as the ability to move between sitting, standing, lifting, kneeling, crouching and bending inherent within work tasks.**

☐ The claimant is able to move through the full range of dynamic work postures, with at the most the assistance of a walking cane or other ambulatory device.

**OR**

☐ The claimant is able to move through a partial range of dynamic work postures but requires physical assistance from another person, in conjunction with a suitable assistive and/or ambulatory device, and requires a prolonged time period.

**OR**

☐ The claimant is totally reliant on physical assistance from another person, despite use of suitable assistive and/or ambulatory devices, to move between all the dynamic work postures.

**(b) Work stamina**

☐ The claimant is able to meet the full (i.e. 75% to 100%) effort tolerance and endurance requirements, with regular breaks.

**OR**

☐ The claimant is able to meet 40% to 75% requirements for effort tolerance and endurance, with prolonged rest periods, the use of good ergonomic principles and assistive devices or support systems.

**OR**

☐ The claimant is able to meet at most 40% requirements for effort tolerance and endurance, despite prolonged rest periods, the use of good ergonomic principles and assistive devices or support system.

**20.3.2. Use of tools and equipment**

☐ The claimant is able to use work tools and equipment in an efficient, dexterous manner, with, at most, ergonomic adaptations to the tools and productivity is not affected.

**OR**

☐ The claimant is able to utilise essential work tools, but the rate of production is significantly reduced, due to diminished co-ordination and/or dexterity.

**OR**

☐ The claimant is totally unable to utilise any work tools and equipment in order to produce the desired output due to diminished upper limb co-ordination and dexterity regardless of the time allowed.

21. Please complete the below assessment scale to describe the nature of the claimant's impairment in relation to the following activities of daily living.

| Activity | Description | 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. | ☐ | ☐ | ☐ |
| 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. | ☐ | ☐ | ☐ |
| Eating | The ability to feed oneself once food has been prepared and made available. | ☐ | ☐ | ☐ |
| Toileting | The ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate. The maintenance of continence is included in this activity of daily living although it may be regarded as an activity of daily living on its own. | ☐ | ☐ | ☐ |

22. In your opinion, as at what date was the claimant last able to work? D D M M Y Y Y Y

23. In your opinion when will the claimant be able to engage in any part of his/her occupation in a:

(a) Part-time capacity? D D M M Y Y Y Y

(b) Full-time capacity? D D M M Y Y Y Y

24. If the claimant has already recovered and returned to work, please provide the date of his/her return to work: D D M M Y Y Y Y

**Thank you for your assistance. We wish to advise that we may be requested to provide a copy of the medical attendant's report to other medical practitioners, other insurers and/or legal representatives.**

**SECTION F: DECLARATION** (to be signed by medical attendant)

I hereby declare that I have personally examined and attended to the claimant and that the contents of this report are true and correct. I accept that a copy of this report can be made available to other parties as stated above.

Signed at _____ on this _____ day of _____ 20 _____

Name of medical attendant

Signature

Hollard Group Risk

# DISABILITY CLAIM FORM – CLAIMANT & EMPLOYER

Please return to: Hollard Group Risk, 22 Oxford Road, Parktown, or PO Box 87428, Houghton 2041. Tel: (011) 351 5000, Fax: (011) 351 3079, email: hgrdisability@hollard.co.za

## SECTION A: HOW TO CLAIM

Two forms are required for the submission of a disability claim.

1. DISABILITY CLAIM FORM – CLAIMANT & EMPLOYER (to be completed by the claimant and the employer)
2. DISABILITY CLAIM FORM – MEDICAL ATTENDANT'S REPORT (to be completed by the claimant/employer and the medical attendant)

The claimant must obtain at his/her own expense, the medical attendant's report from a registered medical practitioner, who is not a member of the claimant's immediate family.

In the event that the claimant is incapacitated, the sections to be completed by the claimant must be completed by the claimant's caretaker and/or the employer. We require an affidavit confirming the claimant's inability to complete and sign the claimant's personal declaration.

It is essential that both forms are fully completed to prevent any unnecessary delays due to missing or incomplete information. It is the employer's responsibility to compile all the documents required and to submit them to Hollard Life. If we ask for an original certified copy of a document we will not accept a certified copy of a previously certified copy.

This form is structured in twelve sections:

- Section A: How to claim (informative section)

To be completed by either claimant or employer or both:

- Section B: Scheme details
- Section C: Employer's details
- Section D: Claimant's personal details
- Section E: Banking details

To be completed by claimant:

- Section F: Claimant's report on employment
- Section G: Claimant's report on claim
- Section H: Declaration

To be completed by employer:

- Section I: Employer's report
- Section J: Declaration

To be completed jointly by the claimant and the employer:

- Section K: Occupational information
- Section L: Declaration

This fully completed form should be accompanied by the following supporting documentation:

- an original certified copy of the claimant's identity document
- a copy of the claimant's payslip for the last completed month of employment
- a copy of the claimant's job description
- a copy of the claimant's sick leave records
- copies of any medical certificates on file with the employer
- proof of continuous premium payment during the waiting period
- proof of banking details (cancelled cheque or bank statement)
- accident report form from the South African Police Services (if applicable)
- accident report required by COID (if applicable)

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Life.

## SECTION B: SCHEME DETAILS (to be completed by employer or claimant)

Employer:

Policyholder:

Policy number:

Membership / Employee number:

**SECTION C: EMPLOYER'S DETAILS** (to be completed by employer or claimant)

Name of company:

Physical address:

Code:

Postal address:

Code:

Contact person:

Job title:

Telephone number:

Fax number:

E-mail address:

**SECTION D: CLAIMANT'S PERSONAL DETAILS** (to be completed by employer or claimant)

First names:

Surname:

Identity number:

Date of birth: D D M M Y Y Y Y Gender: M F

Residential address:

Code:

Postal address:

Code:

Home telephone number:

Cellphone number:

E-mail address:

Occupation:

**SECTION E: BANKING DETAILS** (to be completed by employer or claimant)

If this claim is for a lump sum disability benefit underwritten through an approved policy, payment will be made to the policyholder (the Fund) only. For any other type of disability benefit, payment will be made to the employer, or if the policy allows it, payment may also be made to the claimant.

Please select to whom payment must be made: Policyholder (the Fund) ☐ Employer ☐ Claimant ☐

Name of account holder:

Name of Bank:

Branch:

Branch code:

Account type:

Account number:

**SECTION F: CLAIMANT'S REPORT ON EMPLOYMENT** (to be completed by the claimant)

1. What is your current position?

2. When did you start in your current position? D D M M Y Y Y Y

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

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

5. Have you been able to perform any of your main occupational duties since the onset of your condition? Y N

   If "Yes", please provide details, including dates, and a description of your occupational duties and remuneration.

6. Have you been able to perform in any other occupation since the onset of your condition? Y N

   If "Yes", please provide details, including dates, and a description of your occupational duties and remuneration.

7. Are you currently able to engage in any part of your occupation? Y N

   If "No" when do you expect that you be able to participate on a:

   (a) Part-time basis? D D M M Y Y Y Y

   (b) Full-time basis? D D M M Y Y Y Y

8. If you are not currently working, when do you expect to be able to resume work on a:

   (a) Part-time basis? D D M M Y Y Y Y

   (b) Full-time basis? D D M M Y Y Y Y

**SECTION G: CLAIMANT'S REPORT ON CLAIM** (to be completed by the claimant)

1. What do you understand to be wrong with you?

2. When did you first experience symptoms relating to this condition? D D M M Y Y Y Y

   Please describe these symptoms.

3. Has any of the following contributed in any way to your condition?

| **Nature of contributor** | | **Details** |
|---|---|---|
| Accident (If "Yes", please complete number 4 below) | Y N | |
| HIV | Y N | |
| 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 | |

4. If this claim has arisen from an accident please answer the questions below.

The accident occurred at (place):

On (date): D D M M Y Y Y Y At (time): H H h M M

Name of Police Station where accident was reported

The SA Police case number:

Describe fully how the accident happened:

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

6. Please provide details of the first medical practitioner consulted:

Name:

Telephone number:

Fax number:

Address:

Code:

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

If "Yes", please provide details:

8. Name, address and telephone number of your usual family doctor:

Name:

Telephone number:

Fax number:

Address:

Code:

9. Provide names, addresses and telephone numbers of all other medical practitioners including specialists consulted in connection with this condition.

Name:

Type of practice:

Address:

Code:

Telephone number:

Name:

Type of practice:

Address:

Code:

Telephone number:

Name:

Type of practice:

Address:

Code:

Telephone number:

Name:

Type of practice:

Address:

Code:

Telephone number:

Name:

Type of practice:

Address:

Code:

Telephone number:

10. Have you been referred to any health care professionals e.g. Physiotherapist, Occupational Therapist, Psychologists or other medical specialists? Y N

If "Yes", please provide details:

| Name | Type of Practice/ Specialty | From | To | Treatment | Outcome |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

11. Have you had any tests, X-rays or special investigations relating to your condition or any other impairment? Y N

If "Yes", please provide details:

| Date | Doctor / Hospital | Investigation done | Outcome |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

12. (a) How has your condition been treated?

| Date | Therapy / Medication | Description / Dosage |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

(b) Is future surgery planned / required / anticipated? Y N

If "Yes", please advise when and provide description:

13. Has there been any improvement in your condition? Y N

If "Yes", please provide details.

14. How has this condition affected your ability to perform your activities of daily living?

| Activity | Description | 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. | | | |
| 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. | | | |
| Eating | The ability to feed oneself once food has been prepared and made available. | | | |
| Toileting | The ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate.<br>The maintenance of continence is included in this activity of daily living although it may be regarded as an activity of daily living on its own. | | | |

15. Please provide full details of your current daily activities.

**Morning activities**

**Afternoon activities**

**Evening activities**

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

If "Yes" please provide details in the table below:

| From | To | Country | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

17. Do you intend to reside outside South Africa? Y N

If "Yes" please provide details in the table below:

| From | To | Country | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

18. Please provide details of any benefit, salary or remuneration that you have received or expect to receive as a result of your incapacity including details of salary, benefits from an insurance company, pension fund, state fund or any other source.

| Source of benefit | Name of company and your reference number | Amount |
|---|---|---|
| Monthly disability benefit | | |
| Salary | | |
| Commission | | |
| Other employer earnings | | |
| Pension | | |
| COID/ WCA benefits | | |
| Other insurance benefits | | |
| Other source 1 | | |
| Other source 2 | | |

**SECTION H: DECLARATION** (to be signed by claimant)

I, _____ hereby declare that I am the person insured under the scheme mentioned above.

The answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life.

I agree that all the written statements, reports and affidavits submitted in support of this claim shall constitute part of this claim.

I agree that benefits payable in respect of this claim shall be forfeited if I, or any person acting on my behalf with my consent, have withheld any material fact or submitted any false information in respect of this claim, and that Hollard Life reserves the right to proceed with the appropriate action against the claimant.

Accepting that I am thereby curtailing my right of privacy, but to facilitate the consideration of my claim I irrevocably authorise Hollard Life:

(a) to obtain from any person, whom I hereby so authorise and request to give, any information which Hollard Life deems necessary, and

(b) to share with other insurers that information and any information contained in this claim form or in any related document, either directly or through a data base 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 operators of such data base.

I authorise any medical practitioner, hospital or other person to provide Hollard Life with any information Hollard Life may require relating to my medical history, my injury, my employment history and/or any other information which may be necessary for Hollard Life's consideration of the claim. I also agree that any information provided by me may be verified against other sources or data bases.

Signed at _____ on this _____ day of _____ 20 _____

| | |
|---|---|
| | |
| Claimant's name | Signature |

**In the event that the form was completed on behalf of the claimant:**

| | |
|---|---|
| | |
| Caretaker's name | Signature |

**OR**

| | |
|---|---|
| | |
| Employer's name | Signature |

**SECTION I: EMPLOYER'S REPORT** (to be completed by the employer)

1. When did the claimant join the company? D D M M Y Y Y Y
2. When did the claimant join the disability benefit scheme? D D M M Y Y Y Y
3. Is the claimant a full-time employee? Y N
4. Date appointed as full-time employee? D D M M Y Y Y Y
5. Month last risk premium was paid for? M M Y Y Y Y
6. When was the claimant last able to perform his/her duties in full? D D M M Y Y Y Y
7. Is the claimant still working? Y N

   If "Yes", please provide details of current activities:

8. What was the claimant's salary as at the date that the claimant was no longer able to fulfill the requirements of his/her occupation? R
9. What was the effective date of this salary? D D M M Y Y Y Y
10. Is the claimant still receiving a salary? Y N

    If "Yes", what is the current salary amount? R

    If different from the salary declared in number 8, please advise from which date this new salary was applicable and reason for the difference?

    Reason: Date: D D M M Y Y Y Y

    Until what date do you intend to pay the claimant this salary? D D M M Y Y Y Y

11. When do you expect the claimant to resume work on a:

    (a) Part-time basis? D D M M Y Y Y Y

    (b) Full-time basis? D D M M Y Y Y Y

12. What do you understand to be affecting the claimant's ability to perform the duties of his/her current occupation?
13. At what date was the claimant first unable to perform his/her duties? D D M M Y Y Y Y
14. How is the performance of the claimant's occupational duties being affected by his/her condition?
15. What other alternative occupations within the company would the claimant be capable of performing?

16. If this claim has arisen from an accident at work please answer the questions below.

The accident occurred at (place):

On (date): D D M M Y Y Y Y At (time): H H h M M

Please provide a brief description of your understanding of how the accident happened?

17. Please provide details of any benefit, salary or remuneration received by the claimant from whatever source (e.g. from you the employer, an insurance company, a fund or any other source).

| **Source of benefit** | **Name of company and your reference number** | **Amount** |
|---|---|---|
| Monthly disability benefit | | |
| Salary | | |
| Commission | | |
| Other employer earnings | | |
| Pension | | |
| COID/ WCA benefits | | |
| Other insurance benefits | | |
| Other source 1 | | |
| Other source 2 | | |

**SECTION J: DECLARATION** (to be signed by employer)

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life.

Signed at on this day of 20

Name of authorised signatory

Designation

Signature
For and on behalf of the employer

Company Stamp

**SECTION K: OCCUPATIONAL INFORMATION** (to be completed jointly by the employer and the claimant)

1. Please state the claimant's current job title or position held?

2. Is the claimant responsible for the supervision of any staff? Y N

   If "Yes", please state number of staff supervised:

3. Apart from the claimant's present occupation, please provide a brief job history, including previous positions the claimant has held within the company.

| From | To | Position held | Type of work done |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

4. Please provide details of formal training and any courses attended by the claimant.

| From | To | College or institution | Nature of training | Grade / Standard achieved |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

5. Please select the job description that would be most applicable to the claimant's position.

- ☐ Managerial
- ☐ Supervisory
- ☐ Clerical
- ☐ Machine operator (e.g. driving or using a machine to perform a task)
- ☐ Light manual labour (e.g. physically packing or sorting)
- ☐ Heavy manual labour (e.g. physically digging or loading)
- ☐ Other (Please provide description in the space provided below)

6. Please provide a brief summary of the claimant's main duties in his/her current role?

7. What is the minimum training /education required to perform the claimant's occupation?

| | | | |
|---|---|---|---|
| School | | Standard | |
| Technical | | Diploma | |
| Professional | | Degree | |
| On the job training | | Months | |
| Other | | | |

8. Please complete the questions below on the claimant's work environment.

8.1 What percentage of the working day does the claimant work:

| | | | | | |
|---|---|---|---|---|---|
| Indoors | | % | At heights | | % |
| Outdoors | | % | At depths | | % |

8.2 What is the temperature range in the place of work? degrees centigrade

8.3 What is the decibel range in the place of work? decibels

8.4 Is the claimant exposed to any dust while working? Y N

If "Yes", please state the type of dust the member is exposed to:

8.5 Is the claimant exposed to any fumes while working? Y N

If "Yes", please list all the fumes the claimant is exposed to:

9. What are the daily standard working hours?

**Week:** Start time End time **Week-end:** Start time End time

10. Is shift work required? Y N

If "Yes", please provide details of alternate shift times:

| | | | |
|---|---|---|---|
| Start time | | End time | |
| Start time | | End time | |
| Start time | | End time | |
| Start time | | End time | |

11. Please complete the below on the physical demands of the claimant's occupation:

11.1 Do the claimant's occupational duties involve any of the following? If "Yes", please provide details of the range.

| | | | | |
|---|---|---|---|---|
| Lifting weights | Y N | Range of weights lifted | | kg |
| Carrying weights | Y N | Range of weights carried | | kg |
| Pushing weights | Y N | Range of weights pushed | | kg |
| Pulling weights | Y N | Range of weight pulled | | kg |

11.2 Do the claimant's occupational duties involve any climbing? Y N

If "Yes", please advise type of climbing (e.g. stairs, ladders, scaffolding, etc)

11.3 Please indicate how much time is spent on the following activities during each working day. Only tick the relevant column.

| Activity | Never | Sometimes | Often | Always | Hours per day |
|---|---|---|---|---|---|
| Sitting | | | | | |
| Kneeling | | | | | |
| Standing | | | | | |
| Bending | | | | | |
| Walking on even terrain | | | | | |
| Walking on uneven terrain | | | | | |
| Use of both hands | | | | | |
| Use of fine coordination | | | | | |
| Engaging in physical labour | | | | | |
| Reaching above shoulder height | | | | | |
| Reaching below shoulder height | | | | | |
| Working in cramped conditions | | | | | |

11.4 Where the claimant's occupational duties involve walking, please indicate:

Average distance walked over even terrain per day: km

Average distance walked over uneven terrain per day: km

11.5 Where the claimant's occupational duties involve manual labour, please specify the tasks involved:

12. What hand tools are used to perform the claimant's occupational duties? (e.g. hammer, screwdriver, pen, pencil, etc.)

13. What machines are used to perform the claimant's occupational duties? (e.g. computer, hydraulic lifts, stationary machines, etc.)

14. What materials are used to perform the claimant's occupational duties? (e.g. pipes wood, paint, etc.)

15. What equipment is used to assist the claimant to perform his/her occupational duties? (e.g. trolleys, scaffolding, etc.)

16. Please describe the minimum mental abilities that a healthy individual requires to perform the claimant's occupational duties by completing the table below.

| Abilities required | Very often | Often | Seldom | Examples of tasks requiring these abilities |
|---|---|---|---|---|
| Literacy | ☐ | ☐ | ☐ | |
| Numeracy | ☐ | ☐ | ☐ | |
| Memory | ☐ | ☐ | ☐ | |
| Problem solving | ☐ | ☐ | ☐ | |
| Decision making | ☐ | ☐ | ☐ | |
| Specialised knowledge | ☐ | ☐ | ☐ | |
| Concentration | ☐ | ☐ | ☐ | |
| Planning | ☐ | ☐ | ☐ | |
| Calculations | ☐ | ☐ | ☐ | |
| Administrative tasks | ☐ | ☐ | ☐ | |

17. Please describe the minimum communication skills required to perform the claimant's occupational duties by completing the table below.

| Communication skills required | Very often | Often | Seldom | Aspects of occupational duties requiring these communication skills |
|---|---|---|---|---|
| Speaking | ☐ | ☐ | ☐ | |
| Writing | ☐ | ☐ | ☐ | |
| Memory | ☐ | ☐ | ☐ | |
| Listening | ☐ | ☐ | ☐ | |
| Reading | ☐ | ☐ | ☐ | |
| Public speaking | ☐ | ☐ | ☐ | |

18. Only complete this question if driving is a component of the claimant's occupational duties.

Licence code(s) required:

Type of vehicle(s) driven:

Average distance driven: per day ☐ km per week ☐ km per month ☐ km

19. Only complete this question if flying is a component of the claimant's occupational duties.

Type of aircraft flown:

Average distance flown per week: ☐ km Average number of hours flown per week: ☐

20. Only complete this question if diving is a component of the claimant's occupational duties.

Certification:

Average depth per week: ☐ Average number of dives per week: ☐

Is any mixed gasses used:

21. Only complete this question if mining is a component of the claimant's occupational duties.

Certification:

Is the claimant involved with blasting or explosives? Y N

If yes, please provide details of how the claimant is involved and how often:

What type of mining is undertaken? Opencast Underground

If "Underground" please advise:

How often the claimant goes underground:

Average number of hours spent underground per week:

What activities are performed whilst underground:

22. Only complete this question if going out to sea is a component of the claimant's occupational duties.

Seamen's licence:

How often: How long:

What activities are performed whilst out at sea:

23. Please provide the details of any known safety hazards in the claimant's occupational duties:

**SECTION L: DECLARATION** (to be signed by both the employer and the claimant)

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life.

Signed at _____ on this _____ day of _____ 20 _____

Name of authorised signatory

Designation

Signature
For and on behalf of the employer

Company stamp

Signed at _____ on this _____ day of _____ 20 _____

Claimant's name

Signature

**In the event that the form was completed on behalf of the claimant:**

Caretaker's name

Signature

**OR**

Employer's name

Signature