SACCAWU
National Provident Fund

UNITY DEMOCRACY SOCIALISM!

OLDMUTUAL CORPORATE

APPLICATION FOR **DISABILITY BENEFITS**

GUIDELINES

Please help Old Mutual 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 (please supply the Total Guaranteed Package/Total Cost to Company)	☐
For the commission earners: Salary records for the last 12 months	☐
Payment to Bank	☐

Submit the claim electronically, by fax or post.

Email newclaims@oldmutual.com

Fax 021 509 6855

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.

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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

Scheme 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

Please supply the Total Guaranteed Package Salary/Total Cost to Company in order to calculate the tax in respect of the Group Income Protection benefit. 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. I hereby acknowledge and take note that providing false information on this form is a criminal offense and that criminal charges can be laid against me.

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

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. I hereby acknowledge and take note that providing false information on this form is a criminal offense and that criminal charges can be laid against me.

Signature of employee

Date D D M M Y Y Y Y

Countersigned by bank

OFFICIAL STAMP OF BANK

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NOMINATION FORM FOR THE CASH4♥ONES

Please print in block letters using black or blue ink.

If your monthly income claim is accepted, you will be covered for the cash4♥ones, which is an amount that Old Mutual pays to one nominated person when a claimant passes away.

Please complete this form to state who should receive this benefit and give a copy to the beneficiary.

DETAILS OF THE EMPLOYEE

Surname

Name

Identity number

Date D D M M Y Y Y Y

DETAILS OF THE PERSON WHO SHOULD RECEIVE THE CASH4♥ONES

Surname

First name(s)

Relationship

Identity number

Banking details

Name of bank

Branch code

Account number

Type of account ___ Cheque ___ Savings ___ Transmission

Telephone

Work code number

Home code number

Cellphone

Signature of employee

Date D D M M Y Y Y Y

Disclaimer

This nomination form will only be valid and binding in terms of the relevant policy. Should Old Mutual not be in receipt of the completed nomination form at the date of the claimant's death, Old Mutual will not be liable to pay this benefit. The onus is on the claimant to return the nomination form and Old Mutual does not follow up.

How to apply for the benefit

The beneficiary first phones our Careline on 0860 103 659 and then sends us a death certificate on fax number 021 509 6855 or by post to:

Old Mutual
Disability Claims
PO Box 1659
Cape Town 8000

OFFICE USE

Claimant

Scheme code

Reference number