momentum
employee benefits

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 Ref no:.

Present residential address (as per your record):

Postal code:

Annual income and its composition: R

Last day actively able to perform duties of 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 fax no:

Email:

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	Dates To	Company	Position held	Type of work
DD-MM-2 0 YY	DD-MM-2 0 YY			
DD-MM-2 0 YY	DD-MM-2 0 YY			
DD-MM-2 0 YY	DD-MM-2 0 YY			

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 Momentum 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