momentum

employee benefits

Application for Disability Benefits

Statement by employee

Employee to complete this form

Note: A certified copy of your identity document should be attached to this form.
The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

Name of fund:

Name of company:

1. Particulars of employee

Member Title | Initials

First name/s

Surname

Home language: | Date of birth D D - M M - Y Y Y Y

RSA ID Yes | No | ID/Passport No.

Company employee no.: | Gender: Male | Female

Residential address:

Postal code:

Postal address:

Postal code:

Email

Tel No. (w) | (h) | (c)

Income tax office:

Income tax number:

Date last able to actively perform your own occupation: D D - M M - 2 0 Y Y

an alternative occupation: D D - M M - 2 0 Y Y

2. Details of occupation

1. (a) Date when you started working for your current employer: D D - M M - 2 0 Y Y

   (b) Date when you started in your current occupation/position: D D - M M - 2 0 Y Y

2. Give a brief description of all the important activities of your current occupation/position.

   (a) Job title

   (b) Details of duties-list no more than FIVE key activities and give a brief description of each:

   1.

   2.

   3.

2. Details of occupation (continued)

2. (c) Have you been able to perform part of your job, or another job, since your impairment? Yes ☐ No ☐

(d) If you have performed another job, or if your job was changed, please give details of the job that you did, the date that it changed/started, and salary that you were paid.

3. Apart from your present occupation, please supply a brief job history, including previous positions held.

Dates				
From	To	Company	Position held	Type of work

3. Qualifications, training and experience

	Year	Standard/Qualification
Highest level of schooling:		
Technical qualifications (NTC, diplomas, etc.):		
Academic qualifications (e.g. degrees, etc.):		
Other training (e.g. certificates,in-house training, driver's licences & codes):		

Codes of driver's licences or any other licences that the claimant has: e.g. pilot's licence, engine driver, etc.:

4. Details of impairment

1. Please complete if your impairment arose from an accident or other violent means:

Date of accident: D D - M M - 2 0 Y Y

What type of accident/incident occurred?

Police station where reported:

Police case number:

Please complete if your impairment arose from illness or injury:

List of symptoms/complaints	Date first noticed
	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y

4. Details of impairment (continued)

2. How does the impairment affect you in doing your normal duties?

3a) Which duties can you no longer do?

3b) Which duties can you still do?

4. Please give the names of all doctors, specialists and hospitals you have consulted in connection with your impairment/disability.
Please state patient/hospital numbers where applicable.

Dates					
From	To	Hospital / Doctor	Address	Tel no.	Patient Number

5. Please give the name, address and telephone number of your regular family doctor/general practitioner:

Name

Address

Postal code:

Tel No.

6. If you have changed general practitioners in the last two years, please give details of all previous attending general practitioner/s:

7. Date that you first visited your current general practitioner: D D - M M - 2 0 Y Y

8. When was your last consultation? D D - M M - 2 0 Y Y

9. What alternative occupation(s) do you consider yourself suitable for and what training do you think would be needed for this/these occupations?

5. Personal details

1. Please indicate your hobbies and interests:

2. Please indicate how you generally spend your day since you have been suffering from the impairment:

06h00 - 07h00	
07h00 - 08h00	
08h00 - 09h00	
09h00 - 10h00	
10h00 - 11h00	
11h00 - 12h00	
12h00 - 13h00	
13h00 - 14h00	
14h00 - 15h00	
15h00 - 16h00	
16h00 - 17h00	
17h00 - 18h00	
18h00 - 19h00	
19h00 - 20h00	
20h00 - 21h00	
21h00 - 22h00	

3. Have you, in the last five years, suffered from any serious disease, illness or disablement? Yes ☐ No ☐

If yes, give details

4. Do you belong to a medical aid? Yes ☐ No ☐

If yes, give details

Name of scheme:

Membership no:

When did you join? Give date: D D - M M - 2 0 Y Y

When will your membership stop/when do you expect it to stop?

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?				

2. Have you received any income since the date of disability? Yes ☐ No ☐

If yes, state:

Amount of income and date/s received	Source of income: – e.g. employer, insurance

7. Declaration

I, the undersigned, ______________________

identity number [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

confirm that I have submitted a disability claim against the ______________________ (fund),

and declare that to the best of my knowledge, the particulars given above are true and complete. I further authorise any medical practitioner, hospital, my employer or any other person who may have information relating to my illness/injury, to provide Momentum (the "Insurer") with such information.

I authorise the Insurer to disclose this information to any other party whose opinion is required for the assessment of the disability claim.

Signature of Member	**Signature of Witness**
D D - M M - 2 0 Y Y	D D - M M - 2 0 Y Y
Date	**Date**