GREENLIGHT

RSA

DISABILITY BENEFIT CLAIM FORM

STATEMENT BY EMPLOYER

Contract number

Intermediary Code (e.g. PFA: A123456 BROKER: 78870)

Please print in block letters using black or blue ink.
This form is issued without admission of liability and must be completed and signed by the authorised official.

Please email the completed form to claims@oldmutual.com

Intermediary/Admin support:

Name of contact person

Email address and telephone number of contact person

IMPORTANT NOTES

1. There may be further requirements before the claim can be considered.
2. This form must be completed by the personnel officer of the institution where the life covered was/is employed.
3. Please attach a copy of his/her job description.
4. If applicable a copy of the boarding letter.

SECTION 1 DETAILS OF EMPLOYEE

Title: Mr Ms Mrs Other Initials

Surname

Full names

Previous surname (if applicable)

ID/Passport number

Date of birth D D M M Y Y Y Y

Income tax number

Residential address

Postal code

Postal address

Postal code

Country of address

Contact number (Work) Code No.

(Home) Code No.

Cellphone number

Email address

Pension number

SECTION 2 DETAILS OF OCCUPATION

Name of employer

Period during which the employee was in your employ:

From D D M M Y Y Y Y To D D M M Y Y Y Y

2.1 What was the life covered's occupation immediately before his/her medical condition commenced?

2.2 Please give a complete and accurate description of the exact duties and daily activities of his/her occupation and enclose a copy of his/her job description.

Please also indicate the percentage of time spent/engaged in:

(a) Administrative duties %
(b) Manual duties %
(c) Supervisory duties %
(d) Travelling %

2.3 Please describe how the medical condition has affected his/her ability to perform each of the duties and daily activies listed in 2.2 above.

2.4 Is he/she still engaged in any part of his/her occupation? YES NO

If "YES", please provide exact duties being performed as per 2.2 above.

Please also indicate the percentage of time spent/engaged in:

(a) Administrative duties %
(b) Manual duties %
(c) Supervisory duties %
(d) Travelling %

2.5 (a) When was he/she last actively able to perform any part of the duties of his/her own occupation? (Not official boarding date.) D D M M Y Y Y Y

(b) Official boarding date D D M M Y Y Y Y (Please enclose copy of official boarding letter.)

2.6 Please indicate the date on which he/she became unable to perform each of the occupational duties that have been affected by his/her medical condition:

Occupational duty	Date
	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

SECTION 3 DETAILS REGARDING AN ALTERNATIVE OCCUPATION

3.1 Give a short history of his/her previous positions occupied, up until his/her current position.

Dates		Company	Position occupied	Type of work
FROM	TO			

3.2 Did he/she engage in any occupation (permanent or part-time) after his/her medical condition commenced? YES NO

If "YES", please provide full details.

Name of occupation	From	To
	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
	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

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3.3 Was he/she offered a job elsewhere in the company? YES ☐ NO ☐

If "YES", please give full details including dates.

3.4 Did he/she accept this occupation? YES ☐ NO ☐

If "YES", please give a complete and accurate description of the exact duties and daily activities of this alternative occupation or enclose a copy of a job description of this position.

Please also indicate the percentage of time spent/engaged in:

(a) Administrative duties ___ %
(b) Manual duties ___ %
(c) Supervisory duties ___ %
(d) Travelling ___ %

SECTION 4 INCOME INFORMATION

4.1 Is the life covered receiving any income (including sick leave)? YES ☐ NO ☐

If "YES", please provide full details (for example: full or partial salary).

4.2 Is the life covered receiving any disability benefits from you as a result of his/her medical condition? YES ☐ NO ☐

If "YES", please provide full details

4.3 When will the income/benefits mentioned above cease? D D M M Y Y Y Y

4.4 Is the life covered, to the best of your knowledge, receiving income from any other work activities?

SECTION 5 INFORMATION REGARDING THE MEDICAL CONDITION

5.1 If he/she was injured while in your service, please give a short description of the circumstances of the incident/accident.

5.2 Give particulars of the sick leave taken during the last 2 years, including copies of medical certificates with regard to any period of absence longer than two days.

Dates		Details of illness or injury	Number of working days absent	Medical practitioners consulted
FROM	TO			

Contract number

SECTION 6 DECLARATION BY AUTHORISED OFFICIAL

I, the undersigned, declare that the details provided in this form are true, correct and complete.

Initials Surname

Full names

Capacity

Contact number

Address

Postal code

Signed at (place)

on (date) D D M M Y Y Y Y

Signature of authorised official

OFFICIAL STAMP

Old Mutual Claim Contact Details:

Email	claims@oldmutual.com	Fax number	0860 60 45 02
Telephone number	RSA: 0860 10 22 74 International: +27 21 503 1802	Address	PO Box 202, Mutualpark 7451, South Africa.

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