OLD MUTUAL

Licensed Financial Services Provider

STATEMENT BY EMPLOYER DISABILITY BENEFIT CLAIM FORM E

Old Mutual Life Assurance Company (South Africa) Limited reg. no: 1999/004643/06

Please print in block letters using black or blue ink.

This form is issued without admission of liability and must be forwarded to:
The Department Head
Claims Disabilities Department
Old Mutual
PO Box 1759
Cape Town 8000

This form must be completed by the personnel officer of the institution by whom the assured was/is employed.

A. PERSONAL PARTICULARS OF EMPLOYEE

This certificate is required to substantiate a claim under policy number:

issued on the life of:

First name(s):

Surname:

ID number: Date of birth: d d m m c c y y

Residential address:

Postal code:

Postal address:

Postal code:

B. PARTICULARS OF OCCUPATION

1. What was his/her full-time occupation immediately before his/her impairment?

2. Commencement date of occupation: d d m m c c y y

3. Please give a complete and accurate description of the exact duties and nature of his/her full-time occupation or enclose a copy of his/her job description.

Percentage of time spent engaged in:

(a) admin. duties % (b) manual duties % (c) supervisory duties % (d) travelling by car, truck, etc. %

4. (a) When was he/she last actively able to perform any part of the duties of his/her full-time occupation? (Not official boarding date.) d d m m c c y y

   (b) Official boarding date d d m m c c y y (Please enclose copy of official boarding letter.)

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5. Was he/she engaged in any occupation (permanent or part time) immediately after his/her impairment? YES ☐ NO ☐

If "YES", please provide details, including dates, below.

Name of occupation

Name of occupation	From (d d m m c c y y)	To (d d m m c c y y)

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

If "YES", please provide exact duties being performed as per B.3 (a), (b), (c), (d) above.

(a) ☐☐☐ % (b) ☐☐☐ % (c) ☐☐☐ % (d) ☐☐☐ %

7. Apart from the present occupation, please supply a brief job history of previous positions held.

Dates FROM	Dates TO	Company	Position held	Type of work done

C. INFORMATION REQUIRED WITH REGARD TO ALTERNATIVE OCCUPATIONS

1. Has he/she been considered for another position in your organisation? YES ☐ NO ☐

If "YES", in what capacity?

2. Please give a complete and accurate description of the exact duties and nature of this alternative occupation or attach a copy of the job description.

Percentage of time spent engaged in:

(a) admin. duties ☐☐☐ % (b) manual duties ☐☐☐ % (c) supervisory duties ☐☐☐ % (d) travelling by car, truck, etc. ☐☐☐ %

3. To what extent did his/her education, training and experience qualify him/her for the position? Please justify your answer.

4. Is the position equal to or lower than the position mentioned in B.1?

5. Did he/she accept this position? YES ☐ NO ☐

If "NO", was it due to:

(i) limitation of education/training or experience? YES ☐ NO ☐

(ii) inability to cope physically/mentally? YES ☐ NO ☐

(iii) lack of motivation to adjust? YES ☐ NO ☐

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D. DETAILS OF FUNCTIONAL IMPAIRMENT

1. What was the cause of the impairment?

2. When did the illness first become evident or the injury occur?

3. If he/she was injured on duty, please provide us with a short description of the circumstances of the incident/accident.

4. Please supply brief details of sick leave for the past two years, including copies of medical certificates for any absence exceeding two days. Also indicate days on which he/she left work early (if available).

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

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E. INFORMATION ON INCOME

1. Has he/she suffered any loss of income since the date stated in B.4? YES ☐ NO ☐

   If "YES", please state: gross monthly income prior to impairment ☐☐☐☐☐☐ – ☐

   gross monthly income since impairment ☐☐☐☐☐☐ – ☐

Source of this income:

2. Is he/she entitled to a benefit from any other source as a result of the incapacity? YES ☐ NO ☐

   If "YES", please give full details.

It is hereby declared that, to the best of our knowledge, the particulars above are true and complete.

Signed at ______ this ______ day of ______ 20

Signature

Company stamp

State capacity/designation:

First name(s):

Surname:

Institution name:

Address:

Postal code:

Telephone number: (   )

Fax number: (   )

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The Green Room 11.2005 WT258341