OLDMUTUAL

NAM

Plan number (e.g. 12345678)

Intermediary code (e.g. PFA: A12345678 BROKER: 78870)

GREENLIGHT

DISABILITY BENEFIT CLAIM FORM

STATEMENT BY EMPLOYER

Please print in block letters using black or blue ink.

FOR OFFICE USE ONLY
This claim form has been checked for completeness and accuracy by:

Name of Sales Co-ordinator/Admin. Support person/Intermediary

Email & Tel. no of Sales Co-ordinator/Admin. Support person/Intermediary

This form is issued without admission of liability and must be signed by the Contracting Party or an authorised official on behalf of the Contracting Party and forwarded to:

GREENLIGHT Client Service Centre
PO Box 165
Windhoek
Namibia
Fax: 061 246 795

This form must be completed by the personnel officer of the institution where the Life Covered was/is employed.

SECTION 1 EMPLOYEE'S DETAILS

Surname

First names

Identity number

Date of birth D D M M Y Y Y Y

Residential address

Postal code

Postal address

Postal code

Telephone numbers

(H) Code No.

(W) Code No.

Cellphone number

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 indicate the percentage of time currently 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	
	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

Plan number

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

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

If "YES", please provide 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 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 from you? YES ☐ NO ☐

If "YES", please provide full details.

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

Plan number ☐☐☐☐☐☐☐☐☐☐

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	Doctors consulted
FROM	TO			

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

Signed at ____ on this ____ day of ____ 20 ____

Signature of authorised official

OFFICIAL STAMP

Capacity

Initials Surname

Address

Postal code

Telephone numbers

(W) Code No.

(H) Code No.

Cellphone number

OLDMUTUAL

Plan number