



NAM

GREENLIGHT
DISABILITY BENEFIT CLAIM FORM
STATEMENT BY EMPLOYER

Plan number (e.g. 12345678)

Intermediary code (e.g. PFA: A12345678

BROKER: 78870)

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

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 To

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 activities 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.)

(b) Official boarding date (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

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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

<input type="text"/>	From	<input type="text"/>	To	<input type="text"/>
<input type="text"/>	From	<input type="text"/>	To	<input type="text"/>
<input type="text"/>	From	<input type="text"/>	To	<input type="text"/>
<input type="text"/>	From	<input type="text"/>	To	<input type="text"/>

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

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

<input type="text"/>
<input type="text"/>
<input type="text"/>

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.

<input type="text"/>
<input type="text"/>
<input type="text"/>

Please indicate the percentage of time spent/engaged in:

(a) Administrative duties	(b) Manual duties	(c) Supervisory duties	(d) Travelling
<input type="text"/> <input type="text"/> <input type="text"/> %	<input type="text"/> <input type="text"/> <input type="text"/> %	<input type="text"/> <input type="text"/> <input type="text"/> %	<input type="text"/> <input type="text"/> <input type="text"/> %

SECTION 4 INCOME INFORMATION

4.1 Is the Life Covered receiving any income from you? YES NO

If "YES", please provide full details.

<input type="text"/>
<input type="text"/>
<input type="text"/>

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.

<input type="text"/>
<input type="text"/>
<input type="text"/>

4.3 When will the income/benefits mentioned above cease?

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.

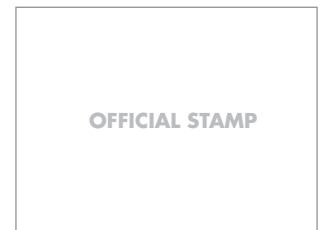
5.2 Give particulars of the sick leave taken during the last 2 years, including copies of medical certificates with regard to any period of absence longer than two days.

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



Capacity

Initials Surname

Address
 Postal code

Telephone numbers

(W) Code No.

(H) Code No.

Cellphone number



Plan number