



Please print in block letters using black or blue ink.

- Submit the claim as soon as possible after the claimant's absence from work commences as this will assist us in providing you with better service.
- If the claim is submitted late, please provide a written motivation for the delay.
- To avoid delays in the assessment process, please provide as much detail as possible and attach all the information on the checklist below.

CHECKLIST

Item	Attached
Section 1 – fully completed and signed by the employer	
Section 2 – fully completed and signed by the claimant	
Confirmation of the date that absence from work commenced	
Salary records for the last 12 months (if a commission earner)	
Payslip as at date when absence from work commenced	
Month in which the employer grants the annual salary increase	
Comprehensive job description – list of the core tasks required of the employee	
Sick leave records with reasons for absenteeism, if possible	
Certified copy of claimant's identity document	
Banking details – claimant and employer or fund if applicable	
Comprehensive medical report(s) / questionnaire from the treating medical specialist relevant to this claim, at claimant's cost	
Beneficiary Assistance Benefit nomination form (only applicable to Selektor monthly income benefits)	

Please refer to the frequently asked questions to assist you with the submission of disability claims.
If uncertain whether it is appropriate to submit a claim, please feel free to contact us.

Contact details:

Group Assurance: Disability Claims (Floor 6M)
Old Mutual Corporate Solutions
PO Box 1659
CAPE TOWN
8000

Tel: (021) 509 6116
Fax: (021) 504 8414
E-mail: GAP_IMS@oldmutual.com

Please print in block letters using black or blue ink.

Fund name	<input type="text"/>
Employer name	<input type="text"/>
Scheme code	<input type="text"/>
Member surname	<input type="text"/>
Member first name(s)	<input type="text"/>
Member's employee number	<input type="text"/>
Date on which member commenced service at company	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> C <input type="text"/> C <input type="text"/> Y <input type="text"/> Y
Date from which member was covered for disability benefit	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> C <input type="text"/> C <input type="text"/> Y <input type="text"/> Y
	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> C <input type="text"/> C <input type="text"/> Y <input type="text"/> Y

Normal retirement date

SECTION ONE TO BE COMPLETED BY THE EMPLOYER

1. EMPLOYER'S DETAILS

1.1 Employer's physical address	<input type="text"/>	Postal Code	<input type="text"/>
1.2 Employer's postal address	<input type="text"/>	Postal Code	<input type="text"/>
1.3 Details of contact person at the company:			
Name and surname	<input type="text"/>		
Job title	<input type="text"/>		
Direct telephone number: Code	<input type="text"/>	No.	<input type="text"/>
Fax number: Code	<input type="text"/>	No.	<input type="text"/>
Cell number	<input type="text"/>		
E-mail address	<input type="text"/>		

2. INCOME DETAILS OF THE EMPLOYEE

Please assist us to verify the employee's income by providing us with a copy of:

- The employee's payslip for the month during which the employee's absence from work commenced
- If employee is a commission earner, basic monthly salary for the last 12 months preceding the day when the employee's absence from work commenced plus commission earned for the last 12 months preceding the day when the employee's absence from work commenced

2.1 Basic annual salary for the month during which the employee's absence from work commenced, on which the premium for cover is based	R	<input type="text"/>
2.2 Date when this salary became effective		<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> C <input type="text"/> C <input type="text"/> Y <input type="text"/> Y
2.3 Month in which the employer normally grants annual salary increases		<input type="text"/> M <input type="text"/> M
2.4 Did the employee receive an increase in salary after the day when absence from work commenced?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
2.5 Does the salary information provided include a 13th cheque?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>

8. TREATMENT

8.1 If you use private health facilities, please provide contact details of your usual **family doctor**:

Name

Address

Postal code

Telephone number: Code No.

When did you first consult with this doctor?

When was your last appointment?

8.2 Please provide contact details of your **medical specialist(s)**:

Name

Address

Postal code

Telephone number: Code No.

When did you first consult with this specialist?

When was your last appointment?

8.3 Please provide contact details of any other health professional you have consulted e.g. Physiotherapist, Occupational Therapist, etc.

Name

Address

Postal code

Telephone number: Code No.

When did you first consult with this health professional?

When was your last appointment?

8.4 If you use **state** health facilities, please provide:

The name of the hospital/clinic

Contact telephone number: Code No.

Name of the treating doctor

Your patient number

Please attach **recent** comprehensive medical report(s) and copies of specialised investigations, e.g. x-ray reports, etc.

9. MEDICAL AID DETAILS

Name of fund

Membership number

Does your medical aid pay for your chronic medication? Yes No

10. HOW DOES YOUR MEDICAL CONDITION AFFECT YOUR DAILY LIFE?

Please complete the following questions if there has been any change in your ability to perform everyday tasks:

10.1 Describe if you cope on your own or need help with daily tasks such as bathroom activities and dressing.

10.2 Describe if you cope on your own or need help with household tasks and food preparation.

Three horizontal lines for text input.

10.3 Comment on your ability to walk, stand, sit, bend, lift and carry.

Three horizontal lines for text input.

10.4 Which kind of transport do you use?

One horizontal line for text input.

10.5 What leisure activities do you do?

Three horizontal lines for text input.

10.6 What is your greatest difficulty at present?

Three horizontal lines for text input.

11. OTHER COMPENSATION

Do you have any other disability insurance cover? Yes No

If "Yes", complete the following:

Table with 2 columns: Insurer, Policy number. Three rows for data entry.

Please Note: please ensure that the following information is provided:

- Certified copy of the claimant's Identity Document
■ Medical report(s)

AUTHORISATION

I hereby declare that the above information is true and correct, and that no information has been withheld or omitted.

Claimant's signature

Signature box for claimant.

Date DD MM CC YY

Name of witness

Name input boxes for witness.

Signature of witness

Signature box for witness.

