



GUIDELINES

Please help Old Mutual Group Assurance to assess your claim correctly, and faster, by using these guidelines.

1. Complete the application form in detail as it gives us important information.
2. Write your answers in clear black or blue block letters so that it is easy to read.
3. Use this checklist to ensure that you hand in all the necessary documents.

Checklist	Tick
Employer section completed and signed	
Claimant section completed and signed	
Copy of the claimant's identification document	
Claimant's full job description or performance contract	
Comprehensive specialist report or completed medical questionnaire	
Sick leave records, with available reasons for absence	
Latest payslip with full salary	
For the commission earners: Salary records for the last 12 months	

Submit the claim electronically, by fax or post.

SOUTH AFRICA

E-mail newclaims@oldmutual.com

Fax 021 509 6855

Group Assurance: Disability Claims (6M)

Old Mutual

PO Box 1659

Cape Town 8000

You are welcome to contact us on telephone 021 504 8758 if you are unsure about any aspect of submitting a claim.

NAMIBIA

E-mail nam-gapnewclaims@oldmutual.com

Fax 061 299 3729

Employee Benefits:

Old Mutual

PO Box 25548

Windhoek



SECTION 1 TO BE COMPLETED BY THE EMPLOYER

1.1 CLAIM INFORMATION

Fund name

Scheme code

Employee's surname

Employee's first name(s)

Employee number

Employment date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Date insurance cover began

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Normal retirement age

1.2 EMPLOYER CONTACT DETAILS

Employer name

Physical address

Province

Postal address

Code Province

Name of contact person

Telephone code number

Cellphone

E-mail

Name of line manager

Telephone code number

1.3 EMPLOYEE INCOME INFORMATION

When did absence from work begin?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

On what basic annual income was the premium based at this date? R

When did this salary become effective?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

What was the employee's basic annual income for the previous three years?

20____, R

20____, R

20____, R

During which month is the annual salary increase granted?

Did the employee received an increase after absence from work began? Yes No

If yes, when?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

1.4 EMPLOYEE JOB DESCRIPTION

Job title

What are the main tasks that the employee must perform?

1.5 EMPLOYEE WORK PERFORMANCE

Is the employee currently on sick leave?

Yes No

If yes, when did sick leave begin?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

If yes, when is the employee expected back at work?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

1.5.1 How did the employee perform *before* the onset of the health condition?

1.5.2 How did the employee perform *after* the onset of the condition? Alternatively, what prevents full productivity?

1.5.3 What accommodations have been made to remove obstacles to productivity, e.g. changes to the employee's duties, work hours, environment or equipment used?

If none are in place, state what accommodations are planned for the future.

1.6 OCCUPATIONAL INJURIES AND DISEASES

Has the employee been injured on duty or developed an occupational disease?

Yes No

If yes, please supply details on the injury or illness.

Please note that the *Insured Claims* process is separate from the *Injury On Duty* process.

1.7 DECLARATION BY EMPLOYER

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

Line Manager

Name

Telephone code number

Fax code number

Signature

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Human Resource Consultant

Name

Telephone code number

Fax code number

Signature

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

SECTION 2 TO BE COMPLETED BY THE EMPLOYEE

2.1 PERSONAL INFORMATION

Surname														
Name(s)														
Identity number						Date of birth	D	D	M	M	Y	Y	Y	Y
Gender	<input type="checkbox"/> Female				<input type="checkbox"/> Male									
Physical address														
											Province			
Postal address														
						Code							Province	
Telephone														
Work	code				number									
Home	code				number									
Cellphone														
E-mail														

2.2 ALTERNATIVE CONTACT DETAILS (Please include the details of a family member, friend or colleague)

Surname											
Name(s)											
Relationship											
Telephone	code				number						
Cellphone											
E-mail											

2.3 AUTHORISATION

I authorise any medical practitioner, health professional, hospital, employer or other person who may be in possession of, or later acquire, any information concerning my health, occupation and earnings to disclose it to Old Mutual at their request. I hereby consent to the use of such information by Old Mutual for assessment and possible reassessment of my disability claim.

Signature of employee												Date	D	D	M	M	Y	Y	Y	Y		
Signature of witness												Name of witness										

2.4 INSURANCE

Complete this question if you have other disability insurance cover.

Insurer												Policy number			

2.5 EDUCATION AND TRAINING

Qualification	Year

2.6 WORK EXPERIENCE DURING THE PAST TEN YEARS

Employer	Job title	Period	Reason for leaving
<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"/>

2.7 WHAT OTHER JOBS COULD YOU DO WITH YOUR QUALIFICATIONS AND WORK EXPERIENCE?

2.8 HEALTH SERVICES

Where do you go for healthcare? Please tick all the applicable options.

Private healthcare
 State hospitals and clinics
 Alternative medicine
 Traditional healer

Name of medical aid

Membership number

Contact details of your doctor(s) or other health professionals

Name of doctor, therapist or clinic	Speciality	Telephone number	Patient number
<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"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Details about your health situation

a) How does the condition affect your self-care (washing, dressing and eating); use of transport; ability to work and enjoy free time?

b) Describe your ability to walk, stand, sit, bend, lift and carry.

c) What is your greatest difficulty at present?

2.9 DECLARATION BY THE EMPLOYEE

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

Signature of employee

Date

Signature of witness

Name of witness