

PROACTIVE INCAPACITY MANAGEMENT NOTIFICATION FORM (2 PAGES)

This form should be faxed to the Incapacity Management Service without delay on the identification of one of the following situations:

- an employee who is off sick for four consecutive weeks
- an employee who is off sick for four weeks within a three month period
- identification of chronic health problems that impacts on productivity
- diagnosis of a progressive disease
- Injury on duty

Fund Name: _____
Company Name: _____
Employee's First Name(s): _____
Surname: _____
Company Reference Number: _____

Date of birth:

c	c	y	y	m	m	d	d

Job title and short description of tasks:

Please ensure that the following information is attached to this form:

- **Background history of the case, i.e. management of the case to date, accommodations at work, medical history, etc.**
- **Medical reports and/or sick leave certificates with regards to the employee's incapacity**

Name and contact telephone number of the contact person(s) at the company

Line Manager (Name) _____
 (Tel) _____
 (E-mail) _____

HR Representative (Name) _____
 (Tel) _____
 (E-mail) _____

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Is the employee currently at work?

Yes/No

If **YES**, please advise how the employee is managing at work, i.e. work hours, job tasks, quality of work performed.

If **NO**, please submit the sick note for the current period of sick leave, and indicate the date when the employee is expected back at work: -

Kindly ask the staff member to complete the information below:

Doctors/specialists consulted:

Doctor's name	Type of doctor/specialist	Contact number	Dates consulted

AUTHORISATION

I hereby 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 the insurer (Old Mutual) at their request.

Signed at _____ this _____ day of _____ 200_____

Claimant's signature

Name in block letters

Signature by Witness

Name in block letters

Designation