



**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	
For monthly income benefits: Beneficiary Assistance Benefit Nomination Form	

Submit the claim electronically, by fax or post.

**SOUTH AFRICA**

E-mail [newclaims@oldmutual.com](mailto: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](mailto: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
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**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

**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

**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 

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

Signature of witness

Name of witness



**If your monthly income claim is accepted, you will be covered for the Beneficiary Assistance Benefit, which is an amount that Old Mutual pays to one nominated person when a claimant passes away.**

**Please complete this form to state who should receive this benefit and give a copy to the beneficiary.**

**DETAILS OF THE EMPLOYEE**

Surname

Name

Identity number

Date

**DETAILS OF THE PERSON WHO SHOULD RECEIVE THE BENEFICIARY ASSISTANCE BENEFIT**

Surname

First names

Relationship

Identity number

Banking details  
 Name of bank   
 Branch code  Account number

Type of account  Cheque  Savings

Telephone  
 Work code  number   
 Home code  number

Cellphone

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Signature of employee

Date

**Disclaimer**

This nomination form will only be valid and binding in terms of the relevant policy. Should Old Mutual not be in receipt of the completed nomination form at the date of the claimant's death, Old Mutual will not be liable to pay this benefit. The onus is on the claimant to return the nomination form and Old Mutual does not follow up.

**How to apply for the benefit**

The beneficiary first phones our Careline on 0860 103 659 and then sends us a death certificate on fax number 021 509 6855 or by post to:

Old Mutual Group Assurance  
 Disability Claims  
 PO Box 169  
 Cape Town 8000

**OFFICE USE**

Claimant

Scheme code  Reference number