

The focus of the Disability Claims Department is to assess the validity of the disability claims submitted. The assessment of occupational disability is done to determine whether the claimant's illness or injury has resulted in inability to perform his / her occupation or a reasonable alternative.

When should a disability claim be submitted?

- As soon as the employer suspects that it is unlikely that an employee, who has stopped working due to illness or injury, will be able to return to work.
- When an employee, who has returned to work after the onset of an illness or injury, is unable to perform work duties.
- When an employee has been diagnosed with a progressive/chronic condition, which is likely to result in a lengthy period of absenteeism from the workplace.
- Generally disability claims may not be submitted later than four weeks after the expiry of the waiting period. Should a claim be submitted later, the employer must attach a *written motivation* for the delay. Refer to the specific policy document that is applicable to the Fund, and clarifies the deadline for submission of disability claims.

What documentation should be submitted?

Please refer to the checklist on page 1 of the application for disability benefits form and ensure that **all** the information on the checklist is provided.

What does Old Mutual consider to be the date that the claimant's absence from work commenced?

This is the date of the day after the claimant ceased to be actively at work. In most situations, eg in case of an accident, the date is clear. However, in some cases, eg frequent absence due to special medical investigations, treatment or relapses, it might be more difficult to pinpoint the day on which the claimant actually stopped performing the job. In such cases, it would be advisable to indicate the day on which the claimant last attended work. This should correlate with the attendance or sick leave records.

What is the waiting period and why is there a waiting period?

A waiting period is a period of absence from the employer's service and is calculated from the commencement of the claimant's absence from work. Duration of waiting periods vary depending on the disability arrangement on the Fund. Waiting periods allow time for Old Mutual to assess the validity of the disability claim.

What medical information must the claimant provide on submission of a claim?

If a claimant is on medical aid, he/she should have been examined, diagnosed and treated by a medical specialist for the health condition or injury for which the claim is being submitted. The claimant's treating medical specialist may complete either the attached medical questionnaire or provide a separate comprehensive medical report, whichever is more convenient.

The report should include past medical history, diagnosis, information relating to a recent medical examination and treatment administered to the claimant e.g. surgery and medication. Test results and reports should be attached to the medical information. These would include X-ray reports, (but not the actual X-rays films,) blood test results etc. Sick certificates or just a diagnosis are not sufficient for us to be able to fairly assess a claim.

If a claimant is not on medical aid, he/she should have been examined, diagnosed and treated by a local clinic or hospital, and this institution is then considered the "treating medical specialist", and the above applies. *Should you be uncertain of any of the above, you are welcome to contact our assessors for assistance.*

Who must pay for this medical information?

Payment for all diagnostic tests, treatment and the provision of the medical information for submission of a claim is for the claimant's cost.

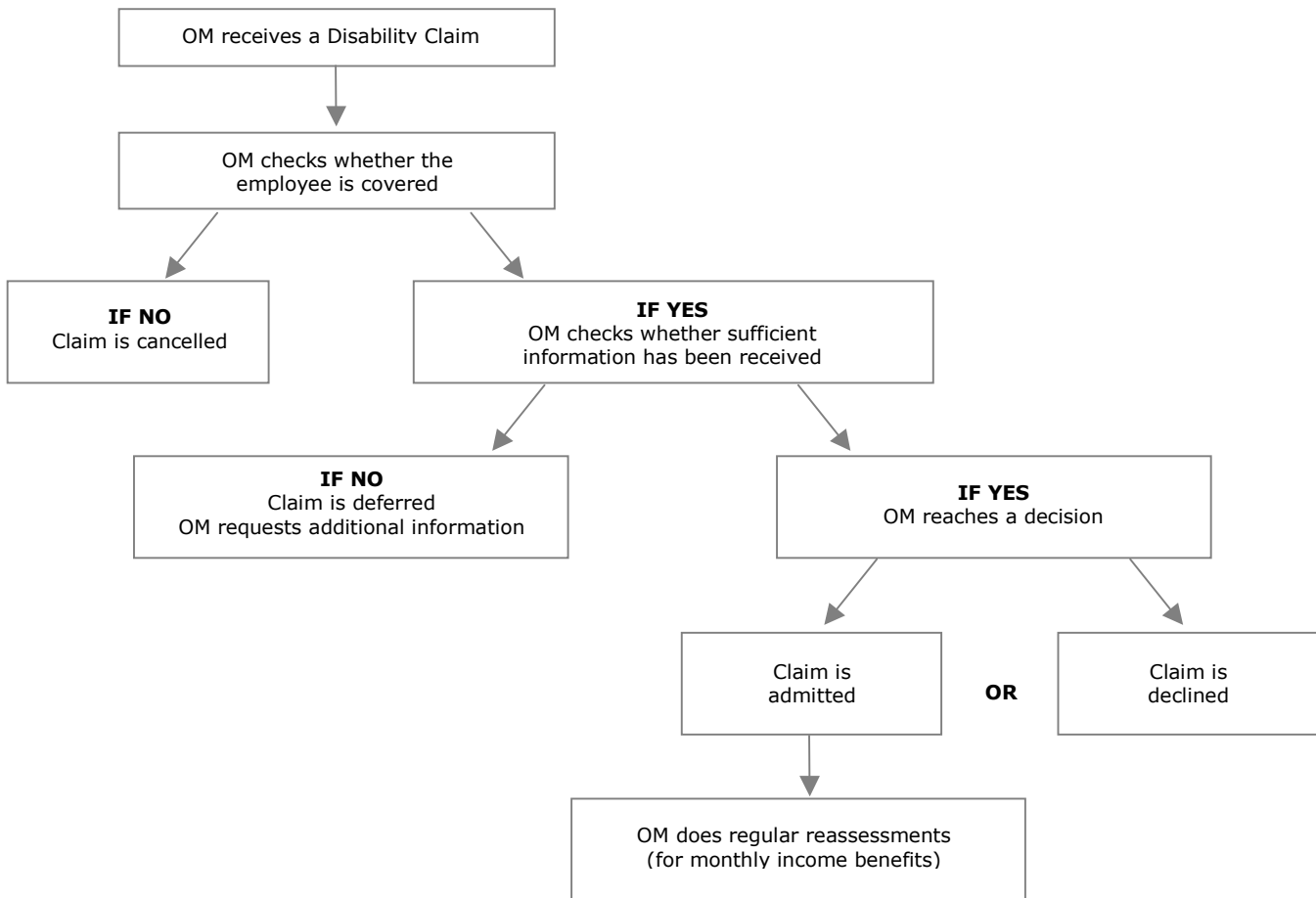
What happens if the assessor requires further clarity on the claimant's medical condition?

If clarity is required on the medical information received, the assessor will contact the treating medical specialist who has provided the information to discuss it further.

If additional medical information from an independent doctor or occupational therapist is required, the claim will be deferred whilst the assessor requests this information. Communication is sent via the broker and/or the employer and may involve making an appointment for the claimant to be examined. Old Mutual will pay for this medical information.

What causes delays in reaching the claim decision?

Any need to "defer" a claim for outstanding or incomplete information may cause delays. Submission of complete information facilitates reaching a decision sooner.



How long does it take to assess the claim and reach a final decision?

Time standards vary according to product, therefore please check your service level agreement, or with the assessor involved with your claim for specifics. The generic time standards are:

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| ■ Temporary disability benefit | 5 working days from receipt of complete information |
| ■ Lumpsum disability benefit | 15 working days from receipt of complete information |
| ■ Monthly income replacement benefit | 15 working days from receipt of complete information |

When will the disability benefit be paid?

If the claim is admitted, the benefit will be paid after expiry of the waiting period.

What is the Beneficiary Assistance Benefit?

This is a new addition to the Selektor and Synergy range of products and pays out a lump sum benefit, equivalent to *three times* the monthly benefit (*applicable to Selektor products*) and *one times* monthly benefit (*applicable to Synergy products*). The benefit is payable to one elected beneficiary, should the claimant die during the payment period. For administrative purposes we have included this nomination form in the claims package. (See annexure 2) It must be completed comprehensively and must be signed by the claimant. Only one beneficiary can be nominated on this form. Kindly note that completion of this form is not a guarantee that the disability claim will be admitted and this should be explained carefully to the claimant.

If an income replacement benefit is approved, how long will the benefit be paid?

This depends on the product under which the benefit is being paid, but it is important to understand

- The benefit is a temporary benefit, paid only while the claimant is unable to work.
- The claimant will be re-assessed periodically to determine whether he/she continues to qualify for the benefit. If he/she does not, the benefit will be terminated, and the claimant asked to return to work either with his/her original employer, or with another in the open labour market.
- Other reasons for termination of a benefit include death, normal retirement date or emigration overseas.