OLD MUTUAL

Licensed Financial Services Provider

Old Mutual Life Assurance Company (South Africa) Limited. Reg. no: 1999/004643/06

Disability Benefit Claim Form B
Statement by Claimant

Please print in block letters using black or blue ink.

This form is issued without admission of liability and must be signed by the assured and forwarded to:

The Department Head
Claims Disabilities Department
Old Mutual Individual Life
PO Box 1759
Cape Town 8000

IMPORTANT: PLEASE CONTINUE PAYING YOUR MONTHLY CONTRIBUTIONS TO AVOID POLICY/BENEFITS CEASING.

1. PARTICULARS OF CLAIMANT

Policy number(s)

Group Schemes (Ex-Colonial Mutual/Voluntary group(s))

Title: Mr ☐ Ms ☐ Mrs ☐ Other ☐ Initials ☐

Surname

Maiden/former surname

First names

Identity number

Passport number (where no South African ID number is available)

Country of issue

Date of birth D D M M Y Y Y Y

Income tax number

Residential address

Postal code

Postal address

Postal code

Telephone

(W) Code No. (H) Code No.

Fax Code No. Cellphone number

Email address

BANKING DETAILS

Name of bank

Branch name Branch code

Accountholder name

Account number

Type of account ☐ Current ☐ Savings ☐ Transmission

2. DETAILS OF OCCUPATION

1. What was your full-time occupation immediately before your current impairment?

2. How long have you been following your present occupation?

3. Please give a complete and accurate description of the exact duties and nature of your full-tiime occupation or enclose a copy of your job description.

Percentage of time spent engaged in:

(a) Administrative duties ___ %

(b) Manual duties ___ %

(c) Supervisory duties ___ %

(d) Travelling by car, truck, etc. ___ %

4. On what date were you last physically able to perform any part of the duties of your full-time occupation (not official boarding date)? D D M M Y Y Y Y

5. Were you engaged in any other occupation (permanent or part-time) immediately after your impairment? YES ☐ NO ☐

If "YES", please give details including dates below.

Nature of occupation

	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y
	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y
	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y
	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y

6. Please state particulars of all occupations followed by you, over the past ten years including dates.

Nature of occupation

	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y
	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y
	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y
	From	D D M M Y Y Y Y	To	D D M M Y Y Y Y

7. (a) Are you still engaged in any part of your main occupation? YES ☐ NO ☐

(b) If "YES", please provide exact duties being performed as per 3(a), (b), (c) and (d) above.

(i) ___ % (ii) ___ % (iii) ___ % (iv) ___ %

8. (a) For what alternative occupation(s) do you consider yourself fitted by education, training or experience?

(b) When do you expect to be able to begin the above alternative occupation(s)?

On a full-time basis? D D M M Y Y Y Y On a part-time basis? D D M M Y Y Y Y

9. Name and address of your employer at the time of your impairment.

10. Have you been pensioned or discharged from your present occupation? YES ☐ NO ☐

If "YES", please attach a copy of your boarding letter from your employer.

11. What school, academic, professional or trade qualifications do you possess?

12. If self-employed, is your business being conducted on your behalf while you are functionally impaired? YES ☐ NO ☐

If "YES", by whom?

If "NO", which of the following duties do you still perform?

(a) Administrative duties ___ %

(b) Manual duties ___ %

(c) Supervisory duties ___ %

(d) Travelling by car, truck, etc. ___ %

3. INFORMATION REGARDING YOUR FUNCTIONAL IMPAIRMENT

1. Describe fully the cause of your impairment (to the best of your knowledge).

2. Describe fully the extent of your impairment.

3. When did you first consult a medical practitioner about your current impairment? D D M M Y Y Y Y

4. Please state dates, names and addresses of all doctors, specialists, clinics and hospitals consulted in connection with this impairment.

5. If your impairment was due to an accident, please state the following:
   (a) Name and addresses of witnesses or other persons involved.
   (b) Address of police station (if any) to which the accident was reported as well as case number (if applicable).

6. If you were hospitalised for your impairment, please state the following:
   (a) Name and address of hospital.

   Date of admission D D M M Y Y Y Y Date of discharge D D M M Y Y Y Y

   Your hospital reference number

7. Have you previously suffered from any disease, illness or accident? YES ☐ NO ☐
   If "YES", please state nature of illness and give names and addresses of doctors and hospitals, including the dates of occurrence.

8. Are you at present under medical care? YES ☐ NO ☐

9. Name and address of the doctor treating you for your impairment.

10. Have you instituted a similar claim against any other company? YES ☐ NO ☐
    If so, state name and address of company.

4. INFORMATION ON INCOME

1. Have you suffered any loss of income since the date stated in section 2.4? YES ☐ NO ☐

   If "YES", please provide:

   Gross monthly income prior to impairment.

   Gross monthly income since impairment.

   Source of this income.

   Did the above income fluctuate prior to disablement? YES ☐ NO ☐

   If "YES", please provide details.

2. Average gross monthly income earned (excluding overtime and business expenses allowed for tax purposes) during the year prior to your current impairment from:

   your full-time occupation.

   any additional occupation.

   Note: Please attach a copy of your latest income tax assessment to this claim form.

3. If you are receiving, or if you expect to receive, any benefit, income or pension while you are functionally impaired, from any employer, any other insurance company, a pension fund, any state fund or from any other source, please provide the following information:

Source of benefit	Amount of benefit	Date of commencement of payment
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y

DECLARATION

PROTECTION OF PERSONAL INFORMATION (PPI) NOTICE

The Old Mutual Group would like to offer you ongoing financial services and may use your personal information to provide you with information about products or services that are suitable to your financial needs. Please sms your ID number to 45600 if you do not want to receive such financial services.

We may use your information or obtain information about you for the following purposes:

- Underwriting
- Assessment and processing of claims
- Credit searches and/or verification
- Claims checks (ASISA Life & Claims Register)
- Fraud prevention and detection
- Market research and statistical analysis
- Audit & record keeping purposes
- To comply with legal & regulatory requirements
- Verifying your identity
- Sharing with service providers we engage to process information on our behalf

You may access the information that we hold about you and ask us to correct any errors or delete the information we have about you. To view our full privacy notice and to exercise preferences, visit our website on www.oldmutual.co.za.

I hereby declare that I am the person assured under the abovementioned policy(policies), that all the particulars given are true and complete, and that my incapacitating condition was not wholly or partly, directly or indirectly, caused by the contingencies mentioned in the exclusions in the conditions of the disability provisions attached to the policy(policies) in question.

Signed at ☐ this ☐ day of ☐ 20

Signature of Claimant

Signature of Witness