

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-time 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)?

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 to

From to

From to

From to

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

Nature of occupation

From to

From to

From to

From to

7. (a) Are you still engaged in any part of your main occupation?

YES NO

(b) If "YES", please provide exact percentage of duties being performed.

Administrative duties

 %

Manual duties

 %

Supervisory duties

 %

Travelling by car, truck, etc

 %

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?

On a part-time basis?

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?

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:

Name and address of hospital.

Date of admission

Date of discharge

Your hospital reference number

7. Have you previously suffered from any disease, illness or accident?

YES NO

If "YES", please state nature of disease, illness or accident and give names and addresses of doctors and hospitals, including the dates of occurrence.

8. Are you under medical care at present?

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.

[Empty text box for company name and address]

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

[Empty text box for gross monthly income prior to impairment]

[Empty text box for gross monthly income since impairment]

Source of this income

[Empty text box for source of income]

Did the above income fluctuate prior to disablement?

YES NO

If "YES", please provide details.

[Empty text box for details of income fluctuation]

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.

[Empty text box for full-time occupation]

[Empty text box for 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

[Empty text box for source of benefit]

[Empty text box for amount of benefit]

[Date grid: D D M M Y Y Y Y]

[Empty text box for source of benefit]

[Empty text box for amount of benefit]

[Date grid: D D M M Y Y Y Y]

[Empty text box for source of benefit]

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[Empty text box for source of benefit]

[Empty text box for amount of benefit]

[Date grid: D D M M Y Y Y Y]

DECLARATION

PROTECTION OF PERSONAL INFORMATION ACT (POPIA) 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 may be suitable to meet your financial needs. Please sms your ID number to **30994** if you would prefer not to receive such information and/or 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 of personal information
- Claims checks (ASISA Life and Claims Register)
- Tracing beneficiaries
- Fraud prevention and detection
- Market research and statistical analysis
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements
- Verifying your identity
- Sharing information with service providers we engage to process such information on our behalf or who render services to us. These service providers may be abroad, but we will not share your information with them unless we are satisfied that they have adequate security measures in place to protect your personal information.

You may access your personal information that we hold and may also request us to correct any errors or to delete this information. In certain cases you have the right to object to the processing of your personal information.

You also have the right to complain to the Information Regulator, whose contact details are:

<http://www.justice.gov.za/inforeg/index.html>

Tel: 012 406 4818

Fax: 086 500 3351

Email: inforeg@justice.gov.za

To view our full privacy notice and to exercise your preferences, please visit our website on www.oldmutual.co.za.

Signed at (place) on (date)

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Signature of recipient

Signature of policy owner/member



Old Mutual is a Licensed Financial Services Provider

Policy number