OLDMUTUAL

GROUP ASSURANCE
SPOUSE'S DISABILITY COVER APPLICATION PACK

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NECESSARY DOCUMENTS TO FILL IN:

- Employee fills in section 1
- Spouse fills in section 2
- Employer fills in section 3
- GP/medical specialist fills in section 4

INFORMATION TO COMPLETE THIS APPLICATION PACK

INSTRUCTIONS FOR THE EMPLOYER to review with the employee

GUIDELINES FOR COMPLETING THIS FORM

1. Fill in all the information on the claim, we can process information quicker this way.
2. Print, stamp and sign the form if you are completing it electronically, then scan and email it to us.
3. Please send us the claim **as soon as you intend to submit.** The maximum period for which we'll accept a submission is within 12 months of the spouse's date of absence or the date of disablement. If the claim is sent after this time, it may be declined due to late submission.
4. We check that the monthly premiums for the employee were paid up until the spouse's date of absence or the date of disablement. Not paying these premiums means the claim will no longer be valid.
5. Do you have all the necessary documents to submit this application? Use the checklists below to assist you.
6. Payment for all diagnostic tests, assessments, treatment and the provision of the medical information for submission of a claim is for the spouse's cost.

IMPORTANT:
Attach all relevant documents based on the list below, then tick them off as you have done so.

FORMS THAT WE ALWAYS NEED (REQUIRED TO START THE ASSESSMENT OF THE CLAIM)	WHOSE RESPONSIBILITY	✓
Completed and signed employee statement (section 1)	Employee	
Completed and signed spouse statement (section 2)	Employee	
Completed and signed employer statement (section 3)	Employer	
A copy of the employee's identity document	Employee	
A copy of the spouse's identity document	Employee	
Proof of spouse's relationship to the employee: • Certified copy of marriage certificate, or • Declaration from a third party confirming the duration of the relationship, on a formal letterhead, signed and stamped, e.g. Tribal Chief, Minister of Religion	Employee	
Spouse's job description (if employed)	Employee	
Comprehensive medical report from the treating medical practitioner (section 4)	Employee	
Employee's latest payslip	Employer	

SEND THE COMPLETED DOCUMENTS TO US:

Our website **oldmutual.co.za/gapforms** contains our claim requirements, as well as useful information and guides to assist you through the claims process. You may also call our HR 911 helpline on 021 509 3911 for any assistance with the claims process.

Email gapdisabilityassessments@oldmutual.com
Fax 021 509 6855

Post Old Mutual Group Assurance Claims (6M)
PO Box 1659
Cape Town 8000
South Africa

PROTECTION OF PERSONAL INFORMATION DISCLOSURE

The Old Mutual Group may use, share or obtain your personal information (including criminal and/or health information) for the following purposes:

- Underwriting
- Assessment and processing of claims
- Where applicable, credit reference searches or verification, credit scoring and assessment and credit management
- Verification of personal information (including your identity, address and banking details)
- Updating your personal information
- Claims checks (Industry Life and Claims Register(s))
- Tracing beneficiaries
- Tracing you where you are uncontactable
- Prevention and detection of fraud, crime, money laundering (including anti-money laundering screening) or other malpractice
- Market or customer satisfaction research or statistical analysis
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements and in connection with legal proceedings.
- 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 agree that Old Mutual may view, search and update your information.

You agree that your medical information may be obtained from and shared with relevant third parties, including reinsurers.

You may access your personal information that we hold and may also, under certain circumstances, 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:

Website: www.justice.gov.za/inforeg/index.html

General enquiries: enquiries@inforegulator.org.za

Complaints: popiacomplaints@inforegulator.org.za

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

APPLICATION FOR SPOUSE'S COVER 1

SECTION 1: **EMPLOYEE DETAILS** (to be completed by the employee)

DECLARATION BY THE EMPLOYEE

I, _____, declare that the information provided by me is true and correct, and that I have provided complete answers.

A NOTE ON FRAUD
By signing this document, you acknowledge that submitting a false claim is a criminal offence and can result in fines and/or imprisonment.

1.1 PERSONAL INFORMATION

Surname	
First name(s)	
Gender:	Female ☐ Male ☐ Preferred language
ID Number	
Physical address	Postal code
Postal address (if different from above)	Postal code
Telephone number	Cellphone number
Email address	
Marital regime with spouse:	Civil Marriage ☐ Civil union ☐ Customary marriage ☐ Life partner ☐
Other	

APPLICATION FOR SPOUSE'S COVER 2

SECTION 2: **SPOUSE APPLICATION** (to be completed by the spouse)

DECLARATION BY THE SPOUSE

I, _____, declare that the information provided by me is true and correct, and that I have provided complete answers.

A NOTE ON FRAUD
By signing this document, you acknowledge that submitting a false claim is a criminal offence and can result in fines and/or imprisonment.

2.1 PERSONAL INFORMATION

Surname

First name(s)

Gender: Female ☐ Male ☐ Preferred language

ID Number

Physical address

Postal code

Postal address (if different from above)

Postal code

Telephone number | Cellphone number

Personal email address

Claim event being claimed for:

☐ Disablement (confinement to bed, paralysis, loss of sight or loss of limbs)

☐ Functional impairment (you are not formally employed and you are unable to perform normal daily tasks)

If either of the above are selected, section 2.2 – 2.4 does not need to be completed

☐ Occupational Disablement (you are formally employed and are unable to work)

If the above is selected, please complete section 2.2 - 2.4

2.2 TELL US ABOUT YOUR CURRENT JOB

Name of employer

Contact person

Designation

Telephone number | Cellphone number

Email address

Employment status: Permanent ☐ Contractor ☐ Terminated ☐ Resigned ☐

Date you started at company D D M M Y Y Y Y

Job title | Year current role began

When did you last work? D D M M Y Y Y Y | Any extra details?

Describe the symptoms you are currently experiencing. How does it affect your work?

Is there anything in the workplace that led to your absence? YES ☐ NO ☐

If yes, please supply details

Is there anything in the workplace that can change in order to allow you to return to work? YES ☐ NO ☐

If yes, please supply details

2.3 TELL US ABOUT YOUR EDUCATION AND TRAINING

FILL IN ALL COMPLETED EDUCATION		YEAR
Highest grade passed:		
Matric:	YES ☐ NO ☐	
Diploma:	YES ☐ NO ☐	
University degree(s):		

2.4 TELL US ABOUT YOUR WORK EXPERIENCE HISTORY INCLUDING YOUR CURRENT JOB

YEARS WORKED	EMPLOYER	MAIN DUTIES

2.5 TELL US ABOUT YOUR ABILITIES

Given your illness, tell us which of the below you can do (mark with an X).

ACTIVITY	ON MY OWN	WITH SOME HELP	WITH A LOT OF HELP	ANYTHING ELSE TO TELL US?
Bathing, dressing, toileting				
Eating & food preparation				
Walking, standing, sitting				
Bending, lifting, carrying				
Childcare				
Banking				
Grocery shopping				
Household tasks				
Driving a car				
Catching a bus/train/taxi				

2.6 AUTHORISATION BY THE SPOUSE

AUTHORISATION

You declare and authorise us to obtain and share personal health information:

I, _____ , expressly consent and authorise Old Mutual:

a) to obtain from any medical practitioner, health professional, hospital, Life and Claims register, employer, insurer, medical scheme and any other person who or institution which may be in possession of, or later acquire, any information concerning my health, occupation; earnings and insurance cover, and

b) to share this information with other parties, health professionals (including employee wellness programmes), the employer, fund, ombudsman, legal representatives or other insurers if necessary, for the purpose of the assessment of my disability claim.

I agree that Old Mutual may use the personal information provided to them in order to verify my identity and check the validity of my claim and to detect and prevent fraud.

I agree that Old Mutual may further use and keep my personal information for historical, statistical, compliance with legal or regulatory requirements and for research purposes, subject to the provisions in the Protection of Personal Information Act 4 of 2013.

I understand that my right to privacy is curtailed to the extent permitted by me in this authorisation. I understand that Old Mutual needs this information to facilitate the assessment of my claim under a group policy.

INDEMNITY

I indemnify Old Mutual and any entity that forms part of the Old Mutual group of companies, including but not limited to any director, employee or agent of these entities and hold them harmless against any claim, loss or damage arising as a result of:

a) a breach of my personal information (including information relating to my health, occupation and earnings) by any medical practitioner, health professional, my employer, fund or other insurer sent to them by Old Mutual with my consent for the purposes of the assessment of my disability claim.

b) the medical evaluation, advice, and treatment I receive from any medical practitioner or health professional to whom Old Mutual has referred me.

c) Incorrect, inaccurate or insufficient medical information provided to Old Mutual, which in turn, is passed to any medical practitioner or health professional for evaluation, advice or treatment relating to my disability.

Surname _____

First name(s) _____

Identity number _____

Date D D M M Y Y Y Y

Your signature _____

2.7 IF YOU HAVE OTHER DISABILITY INSURANCE, COMPLETE THIS SECTION

Complete this question if you have other disability insurance policies.

Insurer | Policy number

Insurer | Policy number

2.8 TELL US ABOUT HOW YOU USE 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

When did you first consult a doctor for your current medical condition? D D M M Y Y Y Y

APPLICATION FOR INCOME PROTECTION 3

SECTION 3: **EMPLOYER APPLICATION** (to be completed by the employer)

IMPORTANT NOTES FOR THE EMPLOYER

1. Are you in an officially recognised position at the employer in order to sign these forms? Please complete the employer declaration.
2. If you provide us with complete and accurate information, we are better able to pay valid claims.

DECLARATION BY THE EMPLOYER

I, _____ the undersigned, in my capacity as _____ am duly authorised to make this declaration as the employer, and hereby declare that the information I provide in this claim is true and correct, and that no information is omitted or withheld.

I indemnify Old Mutual Group Assurance against any claim that may arise from any incorrect information provided in this form.

Surname

First name(s)

Telephone number | Cellphone number

Email address

Signature | Date D D M M Y Y Y Y

3.1 EMPLOYER DETAILS

3.1.1 SCHEME DETAILS

Scheme name

Employer name

3.1.2 EMPLOYER DETAILS

Contact person

Designation

Telephone number | Cellphone number

Email address

Physical address

Postal code

Postal address (if different from above)

Postal code

3.1.3 YOU ARE SUBMITTING THE CLAIM FOR:

Employee's surname

Employee's first name(s)

Date employee joined the fund D D M M Y Y Y Y

Please supply the employee's annual salary R

MEDICAL REPORT 4

SECTION 4: **MEDICAL REPORT**

GUIDELINES AND IMPORTANT INFORMATION FOR THE TREATING MEDICAL PRACTITIONER

1. To assess and manage occupational disability claims, Old Mutual needs updated medical information from the claimant's healthcare provider(s).
2. Please complete the questionnaire by hand, writing as legibly as possible, or compile a typed report that includes all the aspects covered in this questionnaire.
3. Please attach copies of test results that confirm the diagnosis.
4. The claimant is responsible for the cost of this examination and report.
5. Detailed information and your prompt submission will help your patient in their claim application by assisting us to process the claim efficiently.

Thank you for your assistance.

4.1 PATIENT DETAILS

Surname

First name(s)

Identity number

Date of birth D D M M Y Y Y Y

4.2 TO BE COMPLETED BY THE MEDICAL PRACTITIONER

Please provide the medical history.

Describe your current clinical findings.

Please describe the results of any investigations done, including dates.

Diagnosis, with staging if relevant.

Date first consulted for this diagnosis D D M M Y Y Y Y

ICD10 code

If the medical condition being claimed for is psychiatric in nature, please provide the following:

- Mini-mental test score
- GAF score

4.2 TO BE COMPLETED BY THE MEDICAL PRACTITIONER (CONTINUED)

FUNCTIONAL ABILITY

Please tell us more about the claimant's functional ability

ACTIVITY	ON THEIR OWN	WITH SOME HELP	WITH A LOT OF HELP	ANYTHING ELSE TO TELL US?
Bathing				
Dressing				
Toileting				
Eating & food preparation				
Walking				
Standing				
Sitting				
Bending				
Lifting				
Carrying				

TREATMENT

Please describe the treatment of the claimant.

MEDICATION USED	DOSAGES	DURATION	EFFECTIVENESS

Admissions to hospital: duration, reason for admission, and treatment.

DATE OF ADMISSIONS TO HOSPITAL	DATE OF DISCHARGE	REASON FOR ADMISSION	TREATMENT

Other health professionals on the team, e.g. occupational therapy, physiotherapy, speech therapy, etc.

Is the claimant compliant with treatment? If not, please explain.

Is this treatment optimal? If not, what are the obstacles experienced?

What future health management is planned or considered ideal?

What is the prognosis?

4.2 TO BE COMPLETED BY THE MEDICAL PRACTITIONER (CONTINUED)

When will the claimant no longer be impaired by this condition?

When can the claimant perform the functions of their job? D D M M Y Y Y Y

Is the claimant capable of working part time? Please explain.

What is the claimant's motivation to return to work?

Are there other issues at work which could contribute to the claimant's absence?

4.3 REPORTING DOCTOR

Surname | Initials

First name(s)

Speciality

HPCSA number

Practice number

Telephone number | Cellphone number

Email address

Signature | Date D D M M Y Y Y Y

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