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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: <ul style="list-style-type: none"> <li>• Certified copy of marriage certificate, or</li> <li>• 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</li> </ul>	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](http://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 personal information received by Old Mutual in accordance with this contract will be used, as and when appropriate, for the following purposes:

- Underwriting
- Assessment and processing of claims
- Claims checks (Life and Claims Register)
- Fraud prevention and detection
- Tracing beneficiaries
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements
- Verification of the personal information provided

Personal Information will be de-identified when used for market research and statistical analysis.

When Old Mutual engages service providers to process personal information on its behalf or to render services to it, Old Mutual may share some personal information with these service providers, subject to confidentiality agreements being in place between Old Mutual and such service providers. Should these service providers be abroad, Old Mutual will not share the personal information with them unless it is satisfied that adequate security measures are in place to protect the personal information.

The Policyholder is advised and encouraged to inform all members/lives assured that Old Mutual holds and is processing their personal information for the purposes noted above. The Policyholder or a member/life assured may access the personal information relating to him or her and, subject to the provisions this contract may request the correction of any errors or the deletion of this information. In certain cases the Policyholder and members/lives assured have the right to object to the processing of their personal information.

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

**Tel** 012 406 4818

**Fax** 086 500 3351

**Email** [infoereg@justice.gov.za](mailto:infoereg@justice.gov.za)

**Website** [www.justice.gov.za/infoereg/index.html](http://www.justice.gov.za/infoereg/index.html)

To view our full privacy notice and to exercise your preferences, please visit our website on [oldmutual.co.za/privacy-policy/](http://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	<input type="text"/>		
First name(s)	<input type="text"/>		
Gender:	Female <input type="checkbox"/>	Male <input type="checkbox"/>	Preferred language <input type="text"/>
ID Number	<input type="text"/>		
Physical address	<input type="text"/>		Postal code <input type="text"/>
Postal address (if different from above)	<input type="text"/>		Postal code <input type="text"/>
Telephone number	<input type="text"/>	Cellphone number	<input type="text"/>
Email address	<input type="text"/>		
Marital regime with spouse:	Civil Marriage <input type="checkbox"/>	Civil union <input type="checkbox"/>	Customary marriage <input type="checkbox"/> Life partner <input type="checkbox"/>
Other	<input type="text"/>		

## 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	<input type="text"/>		
First name(s)	<input type="text"/>		
Gender:	Female <input type="checkbox"/>	Male <input type="checkbox"/>	Preferred language <input type="text"/>
ID Number	<input type="text"/>		
Physical address	<input type="text"/>		Postal code <input type="text"/>
Postal address (if different from above)	<input type="text"/>		Postal code <input type="text"/>
Telephone number	<input type="text"/>	Cellphone number	<input type="text"/>
Personal email address	<input type="text"/>		

**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

Job title  Year current role began

When did you last work?  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 <input type="checkbox"/> NO <input type="checkbox"/>	
Diploma:	YES <input type="checkbox"/> NO <input type="checkbox"/>	
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:

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

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?



## 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

## 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

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

#### 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

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
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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

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Practice number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Telephone number

Cellphone number

Email address

Signature

Date

D	D	M	M	Y	Y	Y	Y
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