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INITIAL DISABILITY CLAIM ADVICE

ELECTRICAL CONTRACTING INDUSTRY

PENSION ☐ **PROVIDENT** ☐ **LIMITED DURATION** ☐

The details below are to notify NestLife of a potential or pending disability claim. It must be completed where a member:

- Is on sick leave for more than 14 days;
- Is not meeting work requirements due to ill-health and a disability claim may be indicated;
- Is on expected extended absence from work pending medical treatment or surgery

Kindly submit a completed form together with available medical certificates/ sick leave notes/ medical reports to:

NestLife Assurance – Disability Claims Team
Tel: 031 304 2770/ 011 783 9112
Fax: 031 304 2779
E-mail: Donovan@nestlife.co.za

Fund Name:			
Company Name:			
Contact Person:			
Fax Number:		**Tel Number:**	
E-mail address:			
Claimant's Name:			
Date of birth:			
Employee Number:			
Occupation:			
Date last actively at work:			
Cause of disability (if known):			
Name of Person submitting Initial Claim Advice:			
Designation:			
Signature:			
Date:			

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DISABILITY CLAIM CHECKLIST:

ELECTRICAL CONTRACTING INDUSTRY

PENSION ☐ **PROVIDENT** ☐ **LIMITED DURATION** ☐

Name and Surname of member	
Identification Number	
Employee reference number	

Documents Required	Yes	Not Applicable	Comments
A fully completed and signed Declaration by Employer Form			
A fully completed and signed Declaration by Employee Form			
Certified copy of the Member's valid ID document/ passport			
A completed and signed Confidential Medical report (form to be completed by a Treating Specialist)			
Sick leave record for the past 24 months (if available)			
An official sick leave note from the Treating Doctor booking the member off work for the period under assessment			
Medical reports (test results etc.)			
Confirmation of any major medical procedure(s) done in the past 12 – 24 months			
Confirmation of any previous disability claims submitted			
A copy of the member's formal job description			
Member's latest available payslip			
Up to date contribution statement			

	Completed by:	Checked by:
Name		
Signature		
Date		

Underwritten by NestLife Assurance – an Authorised Financial Services Provider: FSP No. 6409 (Registration Number: 1988/703 06/06)
Front Office: 17 Wolmarans Street, 9th Floor-Liberty House, Braamfontein, Johannesburg; Tel: 011 403 9583
Head Office: Commerce Square, Building 3, Corner Rivonia & Melville Roads; Sandhurst, Sandton, 2146
Tel: 011 783 9112, Fax: 011 783 9262 e-mail: info@nestlife.co.za www.nestlife.co.za

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APPLICATION FOR DISABILITY BENEFIT

1. **FORMS TO BE COMPLETED**

   The following forms must be completed for the submission of a claim for a disability benefit:

   - **Declaration by Employer** – to be completed by the Employer
   - **Statement by the Insured** – to be completed by the Claimant/ employee
   - **Confidential Medical Report** – report to be compiled by the Claimant's treating Specialist

   Required supporting documentation:

   - Payslip as at the date of disability
   - Certified copy of the Claimant's Identity document
   - Formal job description
   - Company's Bank details
   - **Sick leave records** – provide copies of all sick leave records for the past 24 months.

   Important – If there are any existing specialist reports available please forward copies with the claim documents.

   Employers are encouraged to notify the Underwriter/ Administrator of a potential Disability claims as soon as they become aware of them.

2. **GENERAL**
   - The Claimant has the initial responsibility of providing medical and other documentary evidence of disability at his/ her own cost. It is the insured's responsibility to prove that he/ she is disabled in terms of the Policy provisions.
   - The Claimant is obliged to submit whatever medical or other information NestLife may reasonably require.

COMLETED CLAIM DOCUMENTATION/ CORRESPONDENCE MUST PLEASE BE SUBMITTED TO:

Donovan Nookiah	e-mail: Donovan@nestlife.co.za	Tel: 011 783 9112/ 031 304 2770

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APPLICATION FOR A DISABILITY BENEFIT

ELECTRICAL CONTRACTING INDUSTRY

PENSION ☐ **PROVIDENT** ☐ **LIMITED DURATION** ☐

PART 1: DECLARATION BY EMPLOYER

1. Name of Fund / Scheme:

Name of Fund / Scheme	
Name of Division / participating Employer	
Contact Person	
Designation	
Telephone number	
E-mail address	

2. Personal details of the Member / Insured:

Full names and surname				
Date of birth	/ /	Identity number		
Reference Number		Gender	Female	Male
Date Joined Company	/ /	Date joined Fund	/ /	
Monthly Pensionable Salary		Retirement Age		

3. Details of Insured's Occupation:

Occupation before disablement				
Name of Immediate Superior				
Telephone number				
Still working	Yes	No	Full Time	Part Time
On Sick Leave	Yes	No	Last day actively at work	/ /
Unpaid Leave	Yes	No	Expected date of return	/ /

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List the essential and regularly performed work tasks with a brief description

Please list the Insured's main duties:

Type of work duty	Weight (%)	Ability to perform		
		Able	Partially Able	Unable

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How often does the insured work in the following conditions?

Work conditions	Frequent	Occasional
Indoors		
Outdoors		
Extreme heat		
Wet areas		
Dust		
Fumes		
Noise		
Walking on uneven surfaces		
Driving		
Operate Machinery		
Other (specify)		

Specify machinery, equipment, tools and materials being used:

Job Demands:

(Complete the necessary details and mark the applicable with an X)

Physical:

Activity	Frequent	Occasional
Standing		
Walking		
Sitting		
Use of both hands		
Reaching above shoulder height		
Reaching below shoulder height		
Climbing and balancing		
Kneeling and Crawling		
Bending		
Lifting and Carrying		
Pushing and pulling		
Working in cramped conditions		
Hearing essential		
Visual acuity essential		
Other, specify		

Indicate the amount of time spent exerting force to lift, carry, push or pull weights:

Force / Weight	Frequent	Occasional
0 – 5 kg		
5 – 15 kg		
15 – 30 kg		
30 – 49 kg		
≥ 50 kg		

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Mental Demands:

Indicate how much of the member's job requires the following abilities:

Ability	Frequent	Occasional
Verbal communication		
Written communication		
Numeracy		
Concentration		
Memory		
Following instructions		
Giving instructions		
Planning		
Problem solving		
Decision making		
Specialised knowledge		
Other, specify		

Sick leave record for the last 24 months:

From date	To date	Number of days taken	Reason

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Describe specific difficulties the insured has in performing his/ her job, with reference to specific duties and environmental factors:

Describe any other factors, either at work or outside work, which could be contributing to the employees difficulties in performing his/ her work duties satisfactorily:

Is it expected that the employee will recover to the extent of returning to work?	Yes	No
If Yes, specify below		
Same job		
Adapted		
Alternative job		
Expected date of return	Full time	Part Time

Describe any efforts made to accommodate the member's impairment or disability by adapting the environment and duties or by placing the member in an alternative work position

List alternative opportunities within the company, together with a brief description, which the employee may be asked to perform in the future

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GENERAL:

Does the member receive or expected to receive any benefits of whatever nature, as a result of his / her disability?	Yes	No

(This income includes income from the Commissioner, pension fund, government fund or any other source)

If YES, please provide the following details:

Regular amounts:

Source of benefits	Amount	Commencement date of payment	Cessation date

Has the insured received either reduced remuneration or no remuneration since disablement?

If YES, please provide details_____

Last date on which the insured received full remuneration: _____/_____/_____

DECLARATION:

I hereby declare that the employee has been informed of the conditions of the Fund rules concerning disability benefits.

I hereby declare and warrant that the information given above is factual, true and correct and that no material information has been withheld nor any relevant circumstances omitted.

Signature:_____ Date_____/_____/_____

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PART 2: DECLARATION BY EMPLOYEE

This declaration will be used for the assessment of your claim. Please ensure each question is answered fully and accurately. The request to complete this form does not constitute an admission of liability by the Insurer.

1. Personal details of the Member / Insured:

Full names and surname				
Date of birth	/ /	Identity number		
Reference Number		Gender	Female	Male
Residential Address				
Postal Address				
Office hours contact number				
Cellular number				
Alternative contact number				

2. Details of education and training:

(Please give details of your highest level of schooling, and training (Academic, Technical, in-service etc.)

Year	Institution	Qualification

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3. Occupational history

Please supply your work history over the past ten (10) years (apart from your current job)

From	To	Company	Position

Current or most recent job				
Company / Division				
Current Employment status	Full time	Part time	Sick leave	Unpaid leave
Date of which you were last actively at work?	/ /			

Please describe your main work duties and functions

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4. Nature of disability and medical care:

Describe the illness/ injury that has given rise to this claim

When did you first consult a medical Doctor / Specialist in connection with the above	/ /
Name of Doctor	
Speciality	
Address	
Date of last Consultation	/ /

Please provide names of Doctors, Specialists, other health professionals and hospitals you have attended in connection with your illness/ injury.

Date	Doctor/ Hospital	Speciality	Address & Contact Number	Treatment/ Surgery received

Details of other concurrent or past illnesses / injuries which you feel may have contributed to you disability:

Current treatment and medication (list all medications and dosages)

5. Details of the impact of your health condition on your work performance:

List the work duties which you are able to perform

List the work duties which you are not able to perform

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Describe specific difficulties you are experiencing in performing your duties

When will you be able to return to your current job?	/ /

If not able to resume your present job, what alternative jobs could you perform in the Company?

Detail any alternative jobs (within or outside the Company or self-employment) you have performed before & after you became ill / injured

Detail any other jobs or income producing activities you may be able to perform in future

6. Details of impact of your health condition on other functions:

Describe the practical implications of your illness/ injury on the following activities of daily living:

Mobility (standing, walking, sitting, bending, carrying etc.)

Self-care (eating, dressing, bathing etc.)

Home Management (domestic chores, gardening, shopping, home maintenance etc.)

Transport (driving, use of public transport etc.)

Sport and recreational activities

Other

7. Details of other income/ compensation:

Are you receiving or do you expect to receive, as a result of or during your disability, any benefit, salary, pension, compensation of whatever nature?	**Yes**	**No**

(This includes income from any employer, partner, Assurance Company, a pension or retirement annuity fund, any governmental fund or any other source)

If Yes, please give the following details:

Regular amounts *(including Life annuities):*

Source of benefits	Amount	Commencement date of payment	Cessation date

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8. Authorisation and Declaration

Authorisation:

I hereby authorise my medical practitioner, the Superintendent of the medical institution, or any other person from whom I have received medical, homeopathic or other treatment, alternatively any department who possesses such medical record to release such medical records and to furnish the said records or copies thereof to NestLife Assurance (the Insurer). I acknowledge and understand that the medical records may contain certain confidential information regarding both my physical and / or mental health.

I hereby authorise NestLife to furnish any information contained in medical reports or otherwise obtained during the course of the assessment of my claim to any health professional that may require such information to assist NestLife in the assessment of my claim.

Declaration:

I hereby declare and confirm that the answers given by me or the information disclosed in this form are complete in all respects, are both true and correct (whether in my handwriting or not) and that no material information has been withheld nor has any relevant information regarding my physical and / or mental health has been omitted, either intentionally or negligently.

Signature of the Claimant	**Date**
Witness	**Date**

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PART 3: CONFIDENTIAL MEDICAL REPORT

An application for a disability benefit has been submitted by one of your patients. Your completion of this report is required in order to assist in the assessment of this claim. Please also attach copies of any reports or results of investigations to substantiate the medical condition(s) of your patient. Any cost in connection with this report will be for the member's account.

1. Personal details of the Member / Insured:

Full name of patient				
Date of birth	/ /	Identity number		
Reference Number		Gender	Female	Male
Employer		Occupation		

Date of first consultation	/ /	**Date of last consultation**	/ /
Height of patient		**Weight of patient**	

Main diagnosis and cause of disablement
Detail the onset and history of the illness/ injury
Concurrent Conditions

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Please give details of your Consultations with the patient over the last 2 years (most recent to the oldest)			
Date	**Complaint**	**Treatment**	**Response**

Details of the last clinical evaluation

Detail objective findings, such as blood tests, X-ray reports, ECG's, echocardiographs and historical reports (*please attach copies thereof*)

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Please comment on the nature and extent of any functional impairment related to the illness/ injury

Does the patient's work duties and / or environments aggravate the illness or injury	Yes (*describe below*)	No

Please provide details of the medial practitioners consulted or of hospital admissions over the past 3 years			
Date	Medical practitioner / Hospital	Speciality	Treatment / Surgery

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Please provide details of present treatment, include mediation and dosages, rehabilitation, counselling etc.

If applicable, please detail any complications or side effects of treatment

Please comment on the patient's response and compliance to current treatment

What further medical treatment, procedures or investigations would you recommend?

What further rehabilitation is envisaged for the patient?

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Prognosis	
When was the Claimant last able to perform his / her Occupational duties?	/ /
Some duties	
All Duties	

If the Claimant is permanently unable to perform his / her Occupational duties, please comment on the types of work he / she may be capable of performing

Other comments or any additional information which will assist in the assessment of this claim

Signature of Medical Attendant			
Name in block letters			
Qualifications / Speciality			
Practise Number			
Date	/ /	Contact number	
Address			