momentum
corporate

Disability claim - employee declaration

Employee/member to complete this form

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

This declaration will form the basis on which the claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Distortion of information could be used as a basis for the claim being declined.

We will also require the Disability Claim Employer Declaration and Disability Claim Confidential Medical Report with copies of all relevant clinical investigation findings in order to assess this claim.

Completed form together with supporting documents to be faxed to 021 917 3711 or emailed to wcc@momentum.co.za or posted to PO Box 2212, Bellville, 7535, attention Momentum Group Insurance disability claims.

1. Scheme details

Scheme name

Employer name

2. Member details

Title | Initials

First name/s

Surname

Date of birth D D - M M - Y Y Y Y

RSA ID Yes ☐ No ☐ ID/Passport No.

Passport country of origin

Gender Male ☐ Female ☐

Marital status Married ☐ Single ☐ Divorced ☐ Widowed ☐

Home language

Telephone - work | Fax

Telephone - home | Cell

Email

Residential address

Postal code

Postal address

Postal code

Income tax office

Income tax number

Do you belong to a medical aid? Yes ☐ No ☐

If yes, give details
Name of scheme

Membership no | When did you join? D D - M M - Y Y Y Y

When will your membership stop/when do you expect it to stop? D D - M M - Y Y Y Y

3. Details of occupation

Date when you started working for your current employer D D - M M - Y Y Y Y

Date when you started in your current occupation/position D D - M M - Y Y Y Y

Job title _____

Details of duties. List five key activities and give a brief description of each.

1. _____

2. _____

3. _____

4. _____

5. _____

Have you been able to perform part of your job, or another job, since your impairment? Yes ☐ No ☐

If you have performed another job, or if your job was changed, please give details of the job that you did, the date that it changed/started, and salary that you were paid.

4. Details of employment history

Apart from your present occupation, please supply a brief employment history, including previous positions held at current and previous employers.

Date started	Date ended	Company	Position held	Type of work	Salary at date of leaving	Reason for leaving

5. Qualifications, training and experience

	Year achieved	Standard/Qualification
Highest level of schooling		
Technical qualifications (NTC, diplomas, etc.)		
Academic qualifications (e.g. degrees, etc.)		
Other training (e.g. certificates,in-house training, driver's licences & codes)		

What alternative occupation/s do you consider yourself qualified for?

6. Details of impairment

Date last able to actively perform your normal occupation D D - M M - Y Y Y Y

an alternative occupation D D - M M - Y Y Y Y

When do you expect to be able to take up any occupation in the future?

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

What is your current employment status? Please tick the appropriate box.

Working full-time ☐	Working part-time ☐	On sick leave ☐	On unpaid leave ☐
Laid off or retrenched ☐	Dismissed ☐	Other ☐	

If Other, please specify. _____

Please complete if your impairment arose from an accident or other violent means.

Date of accident D D - M M - Y Y Y Y

What type of accident/incident occurred? _____

Police station where reported _____

Police case number _____

List of diagnoses/symptoms/complaints.	Date first noticed
	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

How does the impairment affect you in doing your normal duties?

Which duties can you no longer do?

Which duties can you still do?

Have you, in the last 5 years, suffered from any serious disease, illness or disablement? Yes ☐ No ☐

If Yes, please provide details.

Details of any hospitalisations within the last 2 years.

Name of hospital	Date of admission	Date of discharge	Reason for admission	Surgery performed (if applicable)

Current treatment. Please list all medication you are on, provide name and dosage.

6. Details of impairment (continued)

Please give the names of all doctors, specialists and hospitals you have consulted in connection with your impairment/disability.

Dates					
From	To	Hospital / Doctor	Speciality	Tel no.	Patient Number

Please give the name, address and telephone number of your regular family doctor/general practitioner.

Name

Postal address

Postal code

Tel No.

Date that you first visited your current general practitioner D D - M M - Y Y Y Y

When was your last consultation? D D - M M - Y Y Y Y

If you have changed general practitioners in the last two years, please give details of all previous attending general practitioner/s.

Dates				
From	To	Doctor's name	Hospital/Practice name	Tel no

7. Current activity profile

Please indicate your hobbies and interests.

Please indicate how you generally spend your day since you have been suffering from the impairment.

06h00 - 07h00	
07h00 - 08h00	
08h00 - 09h00	
09h00 - 10h00	
10h00 - 11h00	
11h00 - 12h00	
12h00 - 13h00	
13h00 - 14h00	
14h00 - 15h00	
15h00 - 16h00	
16h00 - 17h00	
17h00 - 18h00	
18h00 - 19h00	
19h00 - 20h00	
20h00 - 21h00	
21h00 - 22h00	

8. Income detail

Income prior to your impairment.

Normal salary or wages per month	Bonuses or overtime (monthly average last year)	Commission (monthly average last year)	Other

Current or expected future income.

Source of income e.g. employer, self employment, other insurer, UIF, workman's compensation etc.			
Amount of income			
How payable (monthly, lump sum)			
Date of commencement of payment			
Policy number/s (if applicable)			

9. Employee banking details

Name of account holder			
Name of bank			
Account number		Branch no.	
Account type	Current/cheque ☐	savings ☐	transmission ☐

10. Declaration & consent to collect and share personal and health information

Declaration
I declare that to the best of my knowledge all the particulars given on this claim form are true and correct, and that no material information has been withheld or omitted. I understand that any false and/or misrepresentation of information could be used as a basis for the claim being declined.

Consent to collect and share personal, medical and health information
Momentum will require the collection of personal, medical and health information in order to assess your disability claim. Momentum will therefore have or come into possession of personal, medical and health related information obtained as a result of your disability claim. It may be that third parties are assisting you with your claim and are liaising with Momentum in relation to your claim.

I hereby consent and authorise:

- any health practitioner (e.g. medical practitioner, dentist, occupational therapist, psychologist, etc.), allied health practitioner, hospital, medical aid, employer, insurance company, health risk management service provider appointed by my employer or any other person who has information about my health, employment related activities and personal information, to provide such information to Momentum or any 3rd party nominated by Momentum who requires this information for the purposes of assessing and managing my claim.
- Momentum to furnish any medical, occupational and personal information contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, to a health practitioner, allied health practitioner, health risk management service provider appointed by my employer, or any 3rd party nominated by Momentum who may require such information for the purpose of assisting Momentum in the assessment and management of my claim or for assessing the payment of a benefit provided for in a risk policy where I am the policyholder.
- Momentum to furnish my employer or its duly appointed intermediary with regular claims status reports which will contain personal information. Momentum will not share any health related information in the status reports unless I have given express written consent.
- Momentum to share all medical and health related information (special personal information) with the following third parties:

☐ Employer (including employer representatives) involved with my claim

☐ Financial Advisers and Intermediaries appointed by my employer or myself

☐ Any other person/s appointed by me in writing

☐ All of the above

☐ None of the above

Momentum will share medical and health related information with third parties at its sole discretion. I hereby confirm that I will not hold Momentum, its employees, directors, agents, assigns liable in any manner whatsoever and I hereby indemnify and hold Momentum harmless for the sharing of health related information in terms of this consent.

I hereby confirm that I know and understand this consent I am providing to Momentum herein and that I am doing so of my own free will.

Signature of Member

Date D D - M M - 2 0 Y Y

Options to sign the form:

1. Print out the form, sign and scan it and send it back via email to wcc@momentum.co.za , fax it to Fax +27 (0)21 917 3711 or posted to PO Box 2212, Bellville 7535, attention Momentum Group Insurance disability claims.
2. Place your scanned signature in the signature block by following the steps outlined below.
   - Store your scanned signature as a PDF document in a safe place on your computer.
   - Select the ‘comments’ tab from your menu in Adobe.
   - Select the ‘add stamp’ icon.
   - Select custom stamps.
   - Create custom stamps.
   - You can now browse and upload your signature to save it as a custom stamp under ‘sign here’ in Adobe.
   - You can now go back to your ‘stamps’ icon and select ‘sign here’ and select your saved signature.
   - Place it in the document and save the document.

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