

# Disability Claim

**Please return Claim Forms to:**

1. **Fax to**  
(011) 351-3003
2. **Post Originals to:**  
Life Claims  
P O Box 87428  
HOUGHTON 2041



## TO BE COMPLETED BY THE CLAIMANT

### DETAILS OF INSURED

Policy number .....

Surname .....

First name (s) .....

Date of Birth .....

I.D. number (Please submit proof).....

Residential address .....

Postal address .....

Postal code .....

Telephone number (.....)..... Cell No.....

### EMPLOYER'S DETAILS

Name of employer .....

Address .....

Telephone number (.....).....

1. When did you commence employment with the above employer?.....

2. What was the date that you last attended work?.....

3. (a) Were you working full time for the above employer?.....

(b) If no, please give details.....

4. (a) Are you still receiving a salary/income?.....

(b) If not, up to what date were you paid?.....

(c) If you are still receiving a salary, has the payment been reduced?.....

(d) If yes, please fill in details below

Full pay: from.....to.....Amount.....

Reduced pay: from.....to.....Amount:.....

(e) Did you receive any other benefits from your employer? If so, please state details

.....

.....

Administered by;



**DETAILS OF OCCUPATION**

- 1. What was your main occupation immediately before your current disability commenced?  
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.....
  
- 2. (a) What were the exact duties involved in your occupation immediately before your disability commenced? Please attach a copy of your job description  
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.....  
.....  
.....
  
- (b) What percentage of normal working-hours was spent solely on the following:  
Professional, administrative and/or clerical duties excluding supervision.....%  
Commercial duties i.e. personally buying or selling.....%  
Supervision or inspection of other person's work.....%  
Handling of machinery and/or equipment.....%  
Other duties.....  
Please describe these duties fully.....  
.....  
.....
  
- 3. How long have you followed this occupation?.....
  
- 4. Have you changed your occupation (even temporarily)? If so, please give details.....  
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.....
  
- 5. Previous occupations (if any)? For what periods? .....  
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**DETAILS OF INCOME**

- 1. What salary did you receive over the last 12 months? .....R.....
  
- 2. Are you able to substantiate this figure with a tax assessment payslip etc.? Please attach
  
- 3. If applicable, how much overtime is included in (1) above.....R.....
  
- 4. If applicable, how much commission is included in (1) above.....R.....
  
- 5. During the last 12 months have you earned income from any other source? If so, please give details.....  
.....

**DETAILS OF DISABILITY**

1. What do you understand to be wrong with you?

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.....  
.....

2. State nature and date of earliest symptoms of this disability

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.....  
.....

3. When did you first consult a medical practitioner in connection with your current disability?

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4. Name and address of your usual family doctor

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5. Kindly provide names, addresses and telephone numbers of all medical practitioners (including specialists etc.) consulted in connection with this disability

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6. Have you had any tests or X-rays? Please describe (e.g. date/doctor/hospital)

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7. State the name, address and telephone number of the doctor/hospital treating you at present?

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8. What treatment are you receiving or have you had?

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9. (a) Have you been confined to your home as a result of your current disability?

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(b) If so, please give details and dates

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10. Are you at present unable to manage your personal affairs or care for your personal needs? If so, in what respect ?

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11. If you are not confined to bed, describe briefly your daily activities

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12. Has there been any improvement in your condition? If so, please describe

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13. (a) Have you previously been admitted to a hospital as a result of your current disability?

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(b) If so, please give name/s of institution(s), details of date(s) of admission and discharge and diagnosis.

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14. Have you been treated by any doctors, clinics or institutions for any illness or injury in the five year period prior to the commencement of your current disability? If insufficient space, please use a separate sheet

Date of illness/injury (DDMMYY)	Duration of illness/injury	Nature of illness/injury	Doctor or institution	Tel No.

15. (a) Did your current disability result in you becoming entirely unable to perform the duties involved in your occupation?

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(b) If no, what part of these duties have you been unable to perform?

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 .....  
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16. As regards the duties involved in your occupation:

(a) When were you last able to carry out all your duties?.....

(b) When do you expect to be able to perform some of these duties?.....

(c) When do you expect to be able to perform all of these duties?.....

17. If this claim arises from an accident, please answer these questions below.

(a) What was the date of the accident?.....

(b) How and where did the accident occur?.....

.....  
 .....  
 .....

(c) If a road accident, please supply address of the police station to which the accident was reported

.....  
 .....

(d) Nature of injuries sustained in the accident

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 .....  
 .....  
 .....  
 .....

18. If this claim arises from sickness, please answer this question.

(a) Description of the disease (to the best of your knowledge)

.....  
.....  
.....

(b) When were the symptoms first noticed?.....

(c) Have you ever suffered from this disease in the past?.....

(d) If yes, when?.....

19. (a) Have you received or are you receiving or do you expect to receive any benefit, salary or remuneration whatsoever because of or during your disability? (This includes payments received from any employer, any other insurance company, pension fund, a retirement annuity, any state fund, or from any other source.)

(b) If yes, please give details below:

LUMP SUMS		
Source of Benefit	Amount of Lump Sum	Date of Payment

REGULAR AMOUNTS			
Source of Benefit	Amount of Benefit	Date of Commencement of payment	Date of final payment

**DECLARATION**

I confirm to the best of my knowledge and belief that I am solvent and my Estate has not been sequestrated; that the above policy of insurance/assurance is still my bona fide property and has not been alienated by cession or otherwise, except:

.....  
.....  
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and hereby authorise any medical practitioner, hospital or any other person to furnish HOLLARD LIFE ASSURANCE COMPANY or its appointed representative, with any information relating to my illness or injury. I do hereby declare and warrant that the answers given by me in this report are in every respect factual, true and correct and that no material information has been withheld nor has any relevant information regarding the circumstances been omitted.

Date .....Signature of life assured.....

Date..... Signature of witness.....