

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 EMPLOYER

DETAILS OF EMPLOYER

Policy number

Name of employer

Address of employer

.....Postal code.....

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

EMPLOYEE'S DETAILS OF EMPLOYMENT

Full name of employee

Date of Birth and I.D. number

Date on which employment commenced

Date of last day of work

Normal monthly salary at time of disability

Job title/Occupation

DETAILS OF DISABILITY

1. Please provide specific details of all duties performed by the employee. Please attach a copy of his/her job description
.....
.....
.....
.....
2. What physical positions are adopted by the employee in the performance of his/her duties (e.g. sitting, kneeling, bending, climbing, reaching overhead, lifting etc.)?
.....
.....
.....
.....
3. Describe the difficulties the employee experiences in performing the normal duties of his/her occupation
.....
.....
.....

Administered by;



4. What duties is the employee currently able to attend to?

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

5. Have any attempts been made to redeploy the employee? If so, please provide details

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

6. Please supply a schedule of all medical attention/sick leave taken by the employee in the past 24 months

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

DECLARATION

I declare that all the foregoing statements are true and correct.

Name (Print) Position in company.....

Date (DDMMYY)..... Signature

Stamp