Sanlam

Claim for Spouse's Lump sum disability benefit

Employer Name		Scheme Code	

Important Information

- **It is important that you complete the forms in full. The answers you provide will help us understand the illness/injury that is causing the absence from the workplace and will help to avoid delays in the processing of the claim.**
- It is the spouse's responsibility to prove that they are disabled in terms of the policy provisions.
- The spouse has the initial responsibility of providing medical and other documentary evidence of disability at their own cost.
- The spouse is obliged to submit whatever medical or other information Sanlam may reasonably require.
- **The employer must either post or e-mail the completed forms to:**

Sanlam Corporate: Group Risk Disability Claims (7709)
PO Box 1
Sanlamhof
Bellville, 7532

E-mail address: sgrdisabilityclaims@sanlam.co.za

Forms and documents required

(Sanlam can only assess the disability claim once all the relevant *fully* completed forms and documents have been received)

	Spouse's Claim: Declaration by employer *(pages 2 to 3)*
	Declaration by spouse *(pages 4 to 7)*
	Confidential medical report *Attached Confidential Medical Report to be completed by spouse's treating specialist (or general practitioner, if no specialist is treating the spouse). Form EB2880E attached. If the doctor provides a typed report, the guidelines on page 9 apply.*
	Leave records: Please provide copies of all leave records for the past 12 months. *Sick leave should be clearly marked.*
	Salary statement: Please provide a copy of the insured's latest salary statement as on the last date on which the spouse performed their duties. *In the case of an insured who receives a commission-based salary, we require the past 3 year's salary statements.*
	Copies of insured's and spouse's Identity documents
	Proof of marriage or union

Sanlam Corporate: Group Risk

Please return the completed form and supporting documents to:
sgrdisabilityclaims@sanlam.co.za

SPOUSE'S DISABILITY CLAIM

SECTION A: Declaration by employer (Compulsory, must be completed by the employer)

1. Particulars of the employer	
Name of branch / participating employer	
E-mail address	
Telephone number	

2. Personal details of the insured (NOT the spouse)									
First name(s)									
Surname									
Gender									
RSA identity number*								**Compulsory*	
If not RSA, passport number*								**Compulsory*	
Passport expiry date								*(dd/mm/yyyy)*	
Date of birth								*(dd/mm/yyyy)*	
Marital Status	Single		Married		Divorced		Co-habiting	Widowed	

3. Particulars of membership		
Pay-sheet no. *(if any)*		
Date of entering service		*(dd/mm/yyyy)*
Date of permanent appointment		*(dd/mm/yyyy)*
Commencement date of insurance		*(dd/mm/yyyy)*

Salary information for the past 3 years (* Annual salary is the salary on which premiums paid to Sanlam are calculated)

Date salary received *(dd/mm/yyyy)*	**Annual salary (R)***	**Annual cost to company salary (R)**
	R	**R**
	R	**R**
	R	**R**
	R	**R**

If the scheme has been underwritten by Sanlam for less than one year, please complete the following:		
Type of benefit the spouse enjoyed at the previous insurer		
Cover amount at previous insurer	**R**	
Date from when spouse was covered at the previous insurer		*(dd/mm/yyyy)*

4. Personal details of the spouse						
First name(s)						
Surname						
Previous name (if applicable)						
Gender						
RSA identity number*						*Compulsory*
If not RSA, passport number*						*Compulsory*
Passport expiry date						*(dd/mm/yyyy)*
Nationality	RSA		Other *(please state country)*			
Date of birth						*(dd/mm/yyyy)*
Residential address						
					Postal code	
Postal address					Postal code	
E-mail address (Work)						
E-mail address (Personal)						
Cell phone number			Other contact number			

Signed by the employer on behalf of the scheme			
We, the undersigned, declare on behalf of the scheme that the information provided above is complete and correct. *(the insured's manager, supervisor or any other person who is familiar with the circumstances)*			
Signature			
Initials and surname		Designation	
Date *(dd/mm/yyyy)*		Place	

SPOUSE'S DISABILITY CLAIM

SECTION B: Declaration by Spouse (Compulsory, must be completed by spouse)

1. Personal details of spouse								
First name(s)								
Surname								
Previous name (if applicable)								
RSA identity number*								
If not RSA, passport number*		Country of issue*						**Compulsory*
Passport expiry date								**Compulsory*
Nationality	RSA		Other *(please state country)*					
Date of birth *(dd/mm/yyyy)*		Country of birth						
Type of marriage / union:	Married		Customary		Co-habiting		Religious tenets	
Residential address								
							Postal code	
Postal address							Postal code	
E-mail address (Work)								
E-mail address (Personal)								
Cell phone number		Other contact number						

2. Educational and Occupational history	
Highest school qualification	
Other training/qualifications	

Occupational history: Please give a detailed description of your career history, including your present occupation. The exact date(s) on which service commenced and was terminated, are required:

Name and address of employer	Period in service from *(dd/mm/yyyy)*	Period in service to *(dd/mm/yyyy)*	Nature of work	Reason for leaving

Please describe the most important functions of your occupation directly before disablement:

3. Nature of disability

What do you believe to be the cause of your illness/injury?				
Please describe the symptoms you are experiencing, including how often and how it affects your ability to work:				
Since when have you been experiencing difficulties performing your duties?		*(dd/mm/yyy)*		
On what date did you last actively practice your occupation?		*(dd/mm/yyyy)*		
Have you been able to perform any other occupations or functions since you first became disabled?	Yes		No	
If Yes, please describe these functions:				
Based on your experience and training, what other occupations can you perform?				

4. Disability due to an accident (include a copy of the accident report)

If your disability was caused by an accident, please give the following information:		
Circumstances causing the accident:		
Date of accident		*(dd/mm/yyyy)*
If a formal enquiry was conducted, please state by whom and what the result was:		

5. Medical care

When did you first experience the symptoms?		*(dd/mm/yyyy)*	
When did you see the doctor for the first time regarding these symptoms?		*(dd/mm/yyyy)*	
Access to health care	Public health care		Private health care
If private, please state Medical Aid plan and number			
What treatment have you received (include treatment type and frequency):			
Are you using any assistive devices / technology (hearing aids, walking aids, etc.)			
Please provide us with a list of your current medication and dosages:			

Medication	Dosage

Provide the names and contact details of doctors/specialists/therapists consulted in this regard and provide details:			
Name of doctor / specialist / therapist consulted	**Profession**	**Contact number**	**E-mail address**

Do you suffer from any other medical conditions?	Yes		No	
If Yes, please provide details:				
How do you spend your days?				

Please indicate what activities of daily living you struggle with or are competent to perform:					
BASIC	**Competent**	**Impaired**	**ADVANCED**	**Competent**	**Impaired**
Bowel status			Driving a car		
Bladder status			Medical care: prepare and take correct medicine		
Grooming			Money management		
Toileting			Communicating activities: use of phone, writing letters, etc.		
Feeding			Shopping: Lifting or carrying groceries		
Transfers from chair to bed			Food preparation		
Indoor mobility			Housework		
Dressing			Community mobility with or without assistive device, but not requiring a mobility device		
Stairs			Moderate activities: pushing vacuum cleaner, bowling, etc.		
Bathing			Vigorous activities: running, heavy lifting, etc		

What day-to-day activities that you used to be able to do, are you struggling to do, or are you unable to do, as a result of your illness/injury?

6. Banking details

Please provide us with proof of the banking details for the account holder from the bank as well as the following information:

Name of account holder							
Account number						Name of bank	
Type of account	Savings		Current			Branch code	

7. Consent for Disclosure of Confidential Information and Declaration

I, ______ *(full name(s) and surname of spouse)*

with ID number ______ hereby voluntarily grant authorisation to medical practitioners to disclose my medical and personal records to the medical practitioners appointed by Sanlam to assess (and review) my disability. This includes my previous medical history as well as any psychological or psychiatric records for the purposes of determining my ability to perform work.

I also declare that I have no objections to my medical information being supplied to and obtained from, either directly or through a data base operated by or for insurers as a group, Sanlam's medical advisor, the employer, fund, ombudsman, legal representatives, other insurers, reinsurers and/or the medical service providers involved in the disability assessment and rehabilitation processes if necessary, for the purposes of underwriting risks or assessment and review of any claim for benefits under a policy.

I also irrevocably authorise any medical practitioner, medical specialist, health professional, hospital, medical scheme, or any other person or institution who may be in possession of or who may later obtain possession of any information regarding my health, whether such information pertains to the past or to the future, to disclose such information to Sanlam and I agree that this authorisation will also remain in force even after my death.

I accept and understand that I am limiting my right to privacy to the extent permitted by me in this authorisation, to facilitate the validation and assessment (and review) of my disability claim under the group insurance policy, or any other reason including detection and prevention of fraudulent claims. I acknowledge that I cannot cancel this authorisation and that it will endure even after my death.

I will not hold Sanlam and/or its directors, agents, intermediaries and/or employees liable for any consequences that may arise as a result of such sharing/disclosure and/or collection of my personal information.

I declare that I am the person described above and that the replies given to the questions are true and correct.

Completed and signed at ______ on this ______ day of ______ 20 ______

Signature of spouse ______ Signature of witness ______

______
Full name and surname of witness

Disclaimer: Party Due Diligence requirements

In line with the FIC Amendment Act, 2017 and other Party Due Diligence requirements, Sanlam has the obligation to identify and verify all persons or entities we interact with. Thus, please provide the information as requested in the forms.

Sanlam reserves the right to cancel the insurance immediately if any of the obligations in terms of the FIC Amendment Act, 2017 and other Party Due Diligence requirements are not met.

Protection of Personal Information Disclosure

Why Personal Information is required: Sanlam Life Insurance Limited ("Sanlam Life"), a subsidiary of Sanlam Limited, will process and protect your personal information as required by relevant laws and the Constitution of the Republic of South Africa ("RSA"). The personal information requested in this form, which may include special personal information is being collected and will be processed for the following purposes:

- underwriting and providing accurate and effective insurance cover and related value-added services;
- member communication;
- market research and statistical analysis;
- verification of the personal information provided;
- to comply with all legal and regulatory requirements, including applicable codes of conduct;
- for operational and administrative processes;
- to protect Sanlam Life's interests; and
- any purposes related to the above.

Failure to provide the mandatory information will prejudice your insurance cover.

Changing and correcting Personal Information: You have the right to:

- Request a copy of your personal information as processed by Sanlam Life;
- Ask for an update and/or correction of your personal information;
- Lodge a complaint with the Information Regulator.

Sanlam Life may charge an administrative fee subject to prior notice of any such cost before executing the request for a copy of your personal information.

Other parties that may receive the Personal Information:

- We may share your personal information within Sanlam Limited and/or with other service providers where required for any of the purposes listed above, or with third parties where Sanlam Life is lawfully required to do so.
- We may send your personal information to service providers outside the RSA for storage or further processing on Sanlam Life's behalf. We will not send your information to a country that does not have information protection legislation similar to that of the RSA, unless we have a binding agreement with the service provider which ensures that it effectively adheres to the principles for processing of personal information in accordance with the Protection of Personal Information Act, 2013.

For more information, please refer to the Sanlam Group Privacy Notice.

Sanlam

Guidelines for confidential medical report

Important: The examination and compiling of a medical report must be done by the patient's treating specialist. Only if there is no treating specialist attending to the insured, may a general practitioner complete the report.

Dear Doctor,

Sanlam is in the process of assessing the extent of the patient's disabilities, in view of a claim for disability benefits. To assist us in making a justified decision, we require a report regarding the functional impairment of the patient.

The assessment of a disability claim is based on the principals of **functional impairment** and **disability**. It is important that you are aware of our distinction between the two principles.

- **Functional impairment** is determined by using a medical diagnosis of the functions a person is able to perform and the functions that can no longer be performed.
- **Disability** is determined through a legal process that assesses the extent of a person's functional impairment, judged in conjunction with his/her job description, the policy conditions and personal factors such as education, experience, etc. (This decision will be made by Sanlam Life Insurance Ltd.)

Kindly supply Sanlam with a report, along the guidelines provided below, after you have examined and assessed the **functional impairment** of the patient.

Please note that the patient's identity needs to be established above doubt before proceeding with the examination. Confirm the document/means used to establish the patient's identity, in your report.

Any costs relating to this consultation and medical report is for the patient's account. Should you require additional test / evaluations to establish the patient's functional impairment, the patient will also be responsible for settling these.

Guidelines for a medical report on functional impairment

- Diagnosis (DSM IV/V for psychiatric conditions)
- Date of onset and course of disease
- Severity, perpetual factors, secondary gain
- Current clinical findings. Please provide a detailed description.
- Treatment:
  - Treatment modalities
  - Types of medication and dosage
  - Duration of treatment
  - Therapeutic procedures
  - Rehabilitation
  - Hospitalisation
  - Assistive Devices / technology
  - Date of consultations
- Response to treatment and side effects
- Compliance with treatment
- Complications that are permanent
- Special investigations (e.g. ECG, X-rays, scans, blood tests, laboratory test results, etc.)
- Prognosis with optimal treatment
- Influence on lifestyle, activities of daily living and working capability
- Special requirements:
  - Cardiovascular: NYHA classification, exercise capacity, stress ECG, ejection fraction, echocardiogram, other
  - Respiratory: dyspnea-grading (ATS), exercise capacity, (METS or VO2 max.) vitalogram pre-and post-inhalation (3 attempts), chest X-ray, single-breath diffusion test (Dco) in cases of interstitial lung disease
  - Orthopaedic: X-ray and stress views, MRI or CAT scans, other (e.g. nerve conduction tests)
  - Neurological: MRI, CAT scan results, EKC other
  - Surgery: Surgical report
  - Psychiatric: social functioning, concentration, psychometric tests in cases of cognitive impairment, frequency and dates of consultations
- Immunocompromised conditions: blood tests, CD4 count and viral load