Sanlam

Disability:
Claim for accident benefit

Employer / Fund Name		Scheme Code	

Important Information

- **It is important that you complete the forms in full. The answers you provide will help us understand the injury that is causing the absence from the workplace and will help to avoid delays in the processing of the claim.**
- All references to insured will mean either employee or fund member.
- It is the insured's responsibility to prove that they are disabled in terms of the policy provisions.
- The insured has the initial responsibility of providing medical and other documentary evidence of disability at their own cost.
- The insured 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)

☐	**Declaration by employer** *(page 2)*
☐	**Declaration by insured** *(pages 3 to 5)*
☐	**Confidential medical report** *Report to be compiled by insured's treating specialist according to the "Minimum format for the medical report in respect of an accident benefit claim" attached. (see page 7) If there are any existing specialist reports available please forward copies with the claim documents.*
☐	**Copy of insured's identity document**

Please note: Premium payments must continue until the claim is admitted.

Sanlam Corporate: Group Risk

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

ACCIDENT CLAIM

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

1. Particulars of the fund/scheme

Name of branch / participating employer	
E-mail address	
Telephone number	

2. Personal details of the insured

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 ☐	
Occupation		

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)*

Annual pensionable remuneration of insured	Annual Salary (R)	Date granted *(dd/mm/yyyy)*
(i) On fund /scheme anniversary before the date of the accident		
(ii) On the date of the accident		

Sum insured in respect of accident benefit	**R**			
Date of the last deduction of insured's contribution		*(dd/mm/yyyy)*		
Employer's contribution in respect of the insured was paid / will be paid to:		*(dd/mm/yyyy)*		
Have contributions in respect of the insured been paid regularly and up to date?	Yes ☐	No ☐		
Did the insured on the date of their accident qualify for membership of the fund / scheme?	Yes ☐	No ☐		
Was the insured on the date of their accident a member of the fund / scheme?	Yes ☐	No ☐		
Benefits must be made payable to:	Fund / Scheme ☐	Insured ☐		

Signed by the employer on behalf of the fund/scheme

We, the undersigned, declare on behalf of the fund/scheme that the information provided above is complete and correct.

Signature		**Signature**	
Designation		Designation	
Date *(dd/mm/yyyy)*		Place	

ACCIDENT CLAIM

SECTION B: Declaration by insured (Compulsory, must be completed by the employee)

1. Personal details of the insured							
First name(s)							
Surname							
RSA identity number*							
If not RSA, passport number*							*Compulsory*
Passport expiry date							*Compulsory*
Nationality	RSA		Other *(please state country)*				
Date of birth							*(dd/mm/yyyy)*
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							

2. Nature of disability and medical care		
Name and address of your regular family doctor:		
Since which date have they been your family doctor?		*(dd/mm/yyyy)*
Date of last consultation:		*(dd/mm/yyyy)*

Please provide the names of all doctors, specialists and hospitals that you have consulted in this regard since the accident:

Name of doctor / hospital	Address and contact number	Date	
		From *(dd/mm/yyyy)*	**To** *(dd/mm/yyyy)*

Please describe the circumstances causing the accident		
If a formal inquiry was conducted, please state by whom and what the result was.		
Date of accident		*(dd/mm/yyyy)*

3. General

Please give any further information which, in your opinion, may influence the claim

4. Income

Are you receiving or do you expect to receive, as a result of your accident, any benefit, salary, pension or compensation of whatever nature? *(This includes income from any employer, partner, assurance company, a pension or retirement annuity fund, any government fund or any other source.)* Yes ☐ No ☐

If Yes, please give the following details:

Regular amounts (including life annuities)

Source of benefit	Amount (R)	Commencement date of payment *(dd/mm/yyyy)*	Date of cessation *(dd/mm/yyyy)*

Disability amounts included in ordinary insurance at any other insurer (regardless of whether a claim has been submitted already)

Name of insurer	Amount (R)	Date of payment *(dd/mm/yyyy)*

5. Payment of benefits

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	
Contact details of account holder			
Residential address		Postal code	
Postal address		Postal code	
Contact number			
E-mail address			
Income tax reference number			

6. Consent for Disclosure of Confidential Information and Declaration

I, _____ *(full name(s) and surname of insured)*

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 insured _____ 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.

Minimum format for the Medical report in respect of an accident benefit claim.

Particulars of insured

Initials and surname

Date of birth

Accident details

Before you perform the examination, please determine the insured's identity with the help of a photographic proof of identity. Indicate on the report of your findings - what type of proof of identity was given.

Please supply us with a report in accordance with the guidelines set out underneath after you have examined the insured.

The insured is responsible for the costs relating to this consultation and medical report. Should you require additional investigations, these will also be for the account of the insured.

1. Date of accident.

2. Occupation of claimant.

3. Please state bodily loss that was suffered. (Provide copies of all specialist's reports, and/or X-rays in your possession)

3.1 If the use of the hand(s) or foot/feet or a combination of these was suffered, please provide the following information:

- The clinical diagnosis and prognosis.
- Describe the remaining function of the hand(s) and/or foot/feet and toe(s) and finger(s) in respect of movement, power and sensation.
- If applicable, indicate the amputation levels by means of a sketch.
- Describe the neurological handicap, where applicable.

3.2 If the loss of the use of the eye(s) was suffered, please provide the following information and the latest tests:

- The clinical diagnosis and prognosis.
- Vision acuity test, if relevant.
- Eye movements, where applicable.
- Test of field vision, if possible.

3.3 If the loss of the use of the ear(s) was suffered, please provide the following information and the latest tests:

- The clinical diagnosis and prognosis.
- Audiogram.

4. When did the physical loss take place?

5. Are you the claimant's regular doctor?

5.1 If not, please provide the family doctor's name and telephone number.

5.2 If so, please provide information and dates of any relevant illness or injuries about which you were consulted.

6. If you were at any stage aware of excessive use of alcohol, please provide full information. (Please indicate by whom and where the claimant was treated.)