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OCCUPATION QUESTIONNAIRE

Name:	**Policy Number:**

A. CURRENT EMPLOYMENT DETAILS:

Please indicate of you are: Employed ☐ Self-employed ☐ Unemployed ☐

A 1. Employer or business details: *(If unemployed, please provide details of your last employment)*

a) Name and address of employer or business: _____

_____

_____

_____

_____

_____

b) Contact name: _____

_____

c) Telephone number: _____

_____

d) Email address: _____

_____

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A 2. Job profile: *(If unemployed please provide details for your last employment)*

a) Date employment commenced? _____

_____

b) Job title: _____

_____

c) Please list your key/essential duties: _____

_____

_____

d) Is your position:

Permanent ☐ Temporary ☐ If temporary, please confirm contract end date: _____

_____

Full-time ☐ Part-time ☐ How many hours do you work per week? _____

_____

e) What environment do you work in? (*e.g. office, outdoors, factory.)* _____

_____

f) Please highlight any special conditions that you may be exposed to in your work environment, for example dangerous chemicals or fumes, extreme temperature or dampness, dust, etc.: _____

_____

_____

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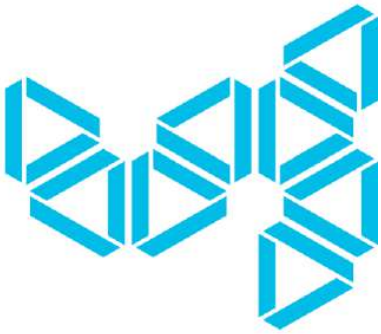

_____

_____

g) Please highlight whether your work involves the use of specialist equipment and/or highly strenuous or potentially dangerous activities: _____

_____

_____

_____

h) Does your work involve management or supervision? No ☐ Yes☐

If yes, how many staff are you responsible for? _____

_____

i) Does your job require any specialist training, skills or qualifications? No ☐

Yes ☐

If yes, please provide further details: _____

_____

j) Does your job involve shift work or on-call work No ☐ Yes ☐

If yes, please provide details of the shift patterns or the on-call work: _____

_____

_____

k) Does your job involve driving: No☐ Yes ☐

If yes, please provides details of the type of vehicle you drive and your average monthly mileage: _____

_____

How far do you travel to your usual place of employment and what form of transport do you use? _____

_____

Do your duties require any other travel (e.g. flying) locally or internationally and if so, how often do you travel? _____

_____

Please attach your latest job description form

A 3. Additional questions for unemployed claimants

a) Date last worked: _____

_____

b) Reason for leaving: _____

_____

c) Daily activities prior to illness: _____

_____

_____

_____

_____

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B. DISABILITY AND EMPLOYMENT

B 1. Please answer the following questions if you are an employee

a) When were you last unable to work as a result of your current medical condition? _____

_____

b) Does your job remain open for you to return to? No ☐ Yes ☐

c) Have you discussed a return to work with your employer? No ☐ Yes ☐

d) Can your employer offer alternate duties? No ☐ Yes ☐

e) Could you return to work if modifications were made? No ☐ Yes ☐

f) Please provide additional information in relation to your responses above: _____

_____

_____

_____

g) What is your planned return to work date? _____

___

h) What was the date of your last performance review and what was your rating? _____

_____

B 2. Please answer the following questions if you are self-employed

a) From what date have you been disabled from working? _____

_____

b) Are you a: Sole proprietor ☐ Partner ☐ Please confirm how many partners are in the business: _

c) How many staff do you employ? _____

_____

d) Does your business continue in your absence and if so, who is running the business? __

_____

e) Do you have any continued involvement? No ☐ Yes ☐

If yes, please confirm the extent of your involvement and what business activities are you undertaking:

Are you receiving and making telephone calls? How many per day? _____

How often do you attend the business premises? _____

Do you continue to manage/supervise staff? _____

How many hours per week are you working? _____

Do you continue to have contact with your clients? If so, please provide further details: _____

_____

f) Do you continue to receive a salary/income from the business? If so, please provide further details: _____

_____

g) What is your current monthly remuneration from the business?_____

_____

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h) Are you a provisional tax payer? _____

i) Income Tax number for SARS _____

j) Do you have any additional businesses? Please provide company names and details. ___

_____

_____

_____

_____

C. PROFESSIONAL (WORK) QUALIFICATIONS

Date	Qualification

D. PREVIOUS WORK HISTORY

Date of employment	Job Title	Employer name and address	occupational duties

E. EDUCATION

Date	Qualifications

F. DECLARATION

I declare that the above statements are to my knowledge true and complete.

Signature:	Date:
Name in block capitals:	

I hereby confirm that the above information is true and accurate as supplied by myself.
I have read and understand the terms and conditions of my policy.
I furthermore give the Insurer consent to obtain further medical evidence or to contact my medical specialists or healthcare providers to discuss my condition in further detail.
I acknowledge that all information asked for in this form is taken into account when assessing the payment of benefit. Please also remember that if you do not answer the questions fully and accurately, benefit may not be paid.
I understand that RMA Life will keep my Personal Information protected as required by South African Law, and will only share the information with a third party for the purposes of assessment of the claim.

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