DISABILITY CLAIM FORM

Please send the completed and signed form, along with any supporting documents, to Old Mutual SME StaffCover at:

Email: claims@oldmutualstaffcover.co.za

Post: Simply Financial Services (Pty) Ltd, Grove Exchange, 9 Grove Ave, Claremont, Cape Town, 7708

IMPORTANT NOTES:

1. Please fill in this Disability Claim Form as completely as you can. Do not leave out any information as that could cause your claim to be delayed or declined.
2. As part of your Disability Claim, you and your employer will also need to fill out detailed questionnaires about the work you do (your current occupation) and whether or not you are able to still do it, or any kind of similar work.

SECTION A: DETAILS OF INSURED PERSON

Full names:

Surname:

ID No:

Residential address:

Home phone number:

Work phone number:

Mobile:

Email address:

Medical Aid:

Medical Aid number: Date joined:

Family doctor/usual GP:

Reasons for seeing your family doctor in the past 3 years:

Please provide full details of all doctor visits, even if they were not related to your current condition

DATE CONSULTED	DIAGNOSIS	TREATMENT RECEIVED

NOTE: *If you need to provide more details about your doctor visits over the past three years, please write these on a separate piece of paper and include it with this form.*

SECTION B: POLICY DETAILS

Policy Number: Date of commencement:

Please provide details of any other Disability policies you hold with any other insurers:

INSURER	POLICY START DATE	HAVE YOU SUBMITTED A CLAIM?

Comment:

SECTION C: CAUSE OF CLAIM

Diagnosis (details of disability condition that you are claiming for):

Date diagnosed: Name of doctor/s that diagnosed you:

List your symptoms that led to the doctor giving the diagnosis above:

When did you first notice these symptoms?

What special tests were done to confirm the diagnosis? (please include dates of tests and copies of results) :

Do you have any other medical condition/s that you are taking medication for currently? **YES:** **NO:**

If you answered yes, what are the conditions you're taking medication for?

On what date did you last go to work?

When (if at all) are you likely to return to work?

SECTION D: TREATMENT

Please list all treatment you have received for this condition, including medication & dosages:

What (if any) side effects of the treatments/medications are you currently experiencing?

Planned future treatment:

Provide details of any rehabilitation program you have undergone, or plan to undergo:

If you have been to hospital for your current condition (disability) please provide details below:

DATE OF HOSPITALIZATION	DIAGNOSIS	TREATMENT RECEIVED	OUTCOME

SECTION E: MEDICAL PRACTITIONERS

Name of doctor treating you for this condition:

Contact number of treating doctor:

Details of specialist/s (if any) treating you for this condition (please include specialty):

SPECIALIST'S NAME	AREA OF SPECIALISATION	CONTACT PHONE NUMBER

Are you seeing any other healthcare practitioner(s) currently? (e.g. physiotherapist, homeopath, chiropractor etc.)

YES: ☐ **NO:** ☐

If you answered Yes above, please provide the details of the other healthcare practitioner/s below:

HEALTH PRACTITIONER'S NAME	AREA OF PRACTICE	CONTACT PHONE NUMBER

SECTION F: CURRENT FUNCTIONAL HEALTH STATUS

Please give details of your current ability to do the following activities:

ACTIVITY	CAN DO IT ON MY OWN	NEED SOME HELP	NEED FULL ASSISTANCE
Getting dressed			
Bathing/showering			

ACTIVITY	CAN DO IT ON MY OWN	NEED SOME HELP	NEED FULL ASSISTANCE
Going to the toilet			
Feeding yourself			
Personal grooming			
Washing your hair			
Preparing a meal			
Cleaning the house			
Driving a car (if applicable)			
Using public transport			
Climbing stairs			
Using a computer			
Managing your personal finances			
Grocery shopping			

Provide details of any rehabilitation program you have undergone, or plan to undergo:What do you find most difficult to do at the moment (and why)?

What do you find most difficult to do at the moment (and why)? **YES:** ☐ **NO:** ☐

If yes, how has it improved?

What would need to change (with your health or body) to make it possible for you to go back to work?

SECTION G: DECLARATION

- I hereby confirm that the information I have provided on this form true and accurate.
- I have read and understand the terms and conditions of my policy.
- I give Old Mutual Alternative Risk Transfer Ltd my permission to obtain further medical evidence or to contact my medical specialists or healthcare providers to get more details about my condition.
- I understand that all the information on this form is considered when assessing my claim and the payment of the benefit.
- I understand that if I have not answered the questions fully, accurately, and honestly, the benefit may not be paid.
- I understand that Old Mutual Alternative Risk Transfer Ltd 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 assessing my claim.

Full name of claimant

Signature **Date**

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