momentum

Employee Benefits
Employee's declaration for a disability claim

Member number

Please attach the following:

- Certified copy of member's identity document
- Employee Benefits job description for a disability claim (completed with your supervisor)

This declaration will form the basis on which your claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Distortion of information could be used as a basis for the claim not to be admitted.

Section 1: Employer details

Name of employer

Residential address

Postal code

Postal address

Postal code

Telephone - work

Fax

Section 2: Member details

Title

Initial/s

First name/s

Surname

Date of birth D D - M M - Y Y Y Y

RSA ID Yes No

ID / Passport number

Passport country of origin

Gender Male Female

Home language

Correspondence language English Afrikaans

Residential address

Postal code

Postal address

Postal code

Telephone - work

Fax

Telephone - home

Cellphone number

Income tax number

Income tax office

Medical scheme name

Medical scheme number

Section 3: Education details

Name of last school attended

Highest standard / grade passed and year obtained

Name/s of universities, colleges or technikons attended and year

Member number

Section 3: Education details (continued)

Degrees and / or certificates obtained and / or courses passed and year

Trade certificates obtained and year

In-house training received and year

Codes of any driver's licences

Section 4: Employment history

Please indicate the member's full employment history at current employer, from the current to the 2nd last position.

	Current	Last (Previous)	2nd last
Date started			
Job title			
Name of employer			
Educational qualifications required for that position			
Experience required for that position			
Broad description of work done			
Date ceased			
Salary at date of leaving (monthly)	R	R	R

When was your last active day at work (having been able to fulfil your normal duties)? D D - M M - Y Y Y Y

What alternative occupation/s do you consider yourself qualified for?

When do you expect to be able to take up any occupation in the future?

On a part-time basis? D D - M M - Y Y Y Y On a full-time basis? D D - M M - Y Y Y Y

What is your current employment status? Please tick the appropriate box.

Working full-time ☐ Working part-time ☐ On sick leave ☐ On unpaid leave ☐

Laid off or retrenched ☐ Dismissed ☐ Other ☐

If Other, please specify

Member number

Section 5: Income details

Income prior to your impairment

Normal salary or wages per month	Bonuses or overtime (monthly average last year)	Commission (monthly average last year)	Other

Current or expected future income

Source of income eg employer, self employment, insurer, UIF			
Amount of income			
How payable (monthly, lump sum)			
Date of commencement of payment			
Policy number/s (if applicable)			

Section 6: Banking details (for payment of benefit)

Employer

Name of account holder

Name of bank

Account number — Branch code - -

Account type — Current / Cheque — Savings — Transmission

Member

Name of account holder

Name of bank

Account number — Branch code - -

Account type — Current / Cheque — Savings — Transmission

Section 7: Medical information

Medical conditions for the claim

Date and details of accident / injury or illness, if applicable

Details of any hospitalisations within the last two years (compulsory)

Name of hospital

Condition

Date of admission D D - M M - Y Y Y Y — Date of discharge D D - M M - Y Y Y Y

Details of any surgery performed in the last ten years

Current treatment. Please list all medication you are on, and the dosages

Member number

Section 7: Details of medical practitioners

General practitioner

Title | Initial/s | First name

Surname

Date first consultation D D - M M - Y Y Y Y

Postal address

Postal code

Telephone - work | Fax

Specialist 1

Title | Initial/s | First name

Surname

Date first consultation D D - M M - Y Y Y Y

Postal address

Postal code

Telephone - work | Fax

Specialist 2

Title | Initial/s | First name

Surname

Date first consultation D D - M M - Y Y Y Y

Postal address

Postal code

Telephone - work | Fax

Speciality

Section 9: Declaration

I declare that to the best of my knowledge all the particulars given on this claim form are true and correct, and that no material information has been withheld or omitted.

I hereby authorise any medical practitioner, hospital or any other person who has information about my health to provide such information to Momentum or any interested party nominated by Momentum who requires this information for the purposes of assessing my claim.

I hereby authorise Momentum to furnish any medical information contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, to any medical practitioner or allied medical practitioner (eg occupational therapist, physiotherapist or psychologist) who may require such information for the purpose of assisting Momentum in the assessment of my claim.

Signature

Witness

Date D D - M M - 2 0 Y Y

Completed form together with supporting documents to be faxed to 012 675 3822 or emailed to EBDisability@momentum.co.za or posted to PO Box 7400, Centurion 0046, attention Momentum Employee Benefits disability claims.