Disability Benefit Application Form

Confidential

PART ONE: EMPLOYER'S

GENERAL PARTICULARS

Name of Fund	PRIVATE SECURITY SECTOR PROVIDENT FUND
Name of Employer/Division	
Member's Surname	First name(s)
Date of Birth	ID number
Member's reference number	
Date joined company	Date joined Fund
Monthly pensionable salary	Retirement age
Monthly address of company/department	
Contact person in company/division	Designation
Telephone Number	Fax number
Email Address	

DETAILS OF EMPLOYMENT

Job title						
Still working	YES	NO	Full-time		Part-time	
On sick leave	YES	NO	Last day actively at work			
Unpaid leave	YES	NO	Expected date of return			

List of essential and regularly performed work tasks with a brief description of each

Type of work duties	**% of time spent performing**
Administrative/Clerical/Professional	
Manual/Handling machinery or equipment	
Commercial work (buying/selling)	
Supervision or inspection	
Other duties, please specify	

Work environment	**% of time spent working**
Office or administrative environment	
Factory or industrial environment	
Working outside	
Driving: specify type of vehicle	
Other, please specify	

Exposure to adverse conditions	Exposure (yes/no). if yes, describe		
Extreme temperatures	yes	no	
Noise	yes	no	
Dust	yes	no	
Fumes	yes	no	
Heights/Depths	yes	no	
Rough terrain	yes	no	
Other hazards, please specify	yes	no	

Specify machinery, equipment, tools and materials being used

Complete the table below indicating the amount of on-the-job time spent on the following activities each working day:

PHYSICAL DEMANDS

Activity	Never	Sometimes	Often	Always
Standing				
Walking				
Sitting				
Use both hands				
Reaching above shoulder height				
Reaching below shoulder height				
Climbing and balancing				
Kneeling and crawling				
Bending				
Lifting and carrying				
Pushing and pulling				
Working in cramped conditions				
Hearing essential				
Visual acuity essential				
Other, please specify				

Indicate the amount of time spent exerting force to lift, carry, push or pull weights

Force/Weight	Never	Sometimes	Often	Always
0 to 5kg				
5 to 15kg				
15 to 30kg				
30 to 50kg				
More than 50 kg				

MENTAL DEMANDS

Indicate how much of the member's job requires the following abilities

Abilities	Never	Sometimes	Often	Always
Verbal communication				
Written communication				
Calculations/figure work				
Concentration				

Abilities	Never	Sometimes	Often	Always
Memory				
Following instructions				
Giving instructions				
Planning				
Problem solving				
Decision-making				
Specialised knowledge				
Other, specify				

Complete the member's sick leave record for the last 2 (two) years

Date from	Date to	Numbers of working days	Reason

Describe the specific difficulties the member has in performing his/her job, with reference to specific duties and environmental factors

Describe any other factors, either at work or outside work, which could be contributing to the employee's difficulties in performing his/her work duties satisfactorily

Is it expected that the employee will recover to the extent of returning to work?	YES	NO

If Yes, specify below

Same job

Adapted

Alternative job

Expected date of return	Full-time		Part-time	

Describe any efforts made to accommodate the member's impairment(s) or disability by adapting the environment and duties or by placing the member in an alternative work position

List alternative jobs in the company, together with a brief description, which the employee may be asked to perform in the future

Details of benefits/Compensation from other sources as a result of disability (Current or anticipated)

Source	Amount	Date of payment	Period of payment

DECLARATION BY EMPLOYER

I hereby declare that the employee has been informed of the conditions of the Fund rules concerning disability benefits.

I hereby declare and warrant that the information given above is factual, true and correct, and that no material information has been neither withheld nor any relevant circumstances omitted.

Signature

Designation

Date

Company stamp

Please attach the following:

* **Last payslip * original certified copy of ID * Formal job description, if available**
* **Sick leave records over the last 2 (two) years with copies of sick leave certificates**

PART TWO: EMPLOYEE'S DECLARATION

This declaration will be used in the assessment of your claim. Please ensure that each question is answered fully and accurately. The request to complete this form in no way constitutes an admission of liability by the Fund or the insurer.

PERSONAL PARTICULARS

Surname	First Names
Date of Birth	ID Number
Employee Number	Employer Name
Medical Aid Scheme	Medical Aid Number
Residential Address	
Post Code	
Postal Address	
Post Code	
Office Hours contact number	Home contact number
Alternative contact number	Cellular Number

Please give details of your highest level of schooling, post-school education and training (academic, technical, in-service, etc.)

DETAILS OF EDUCATION AND TRAINING

Year	Institution	Qualification/s

Apart from your present job, please supply your work history over the past 10 (ten) years

DETAILS OF WORK

From	To	Company	Position

Current or most recent job

Company/Division

Current employment status: Full-time ☐ Part-time ☐ Sick leave ☐ Unpaid leave ☐

Date on which you were last actively able to do this job?

Please describe your main work duties and functions?

DETAILS OF DISABLEMENT AND MEDICAL CARE

Describe the illness/injury that has given rise to this claim

When did you first consult a medical Doctor/Specialist in connection with the above?

Name of Doctor	Date
Specialty	Telephone Number
Address	
Post Code	

Details of your usual family/general practitioner

Name of Doctor	Telephone Number
Address	
Post Code	
Date of last consultation	

Please give the names of doctors, specialists, other health professionals and hospitals you have attended in connection with your disability

From	To	Doctor/Hospital	Specialty	Address and Telephone Number	Treatment/Surgery received

Details of other concurrent or past illnesses/injuries which you feel may have contributed to your disability

Current treatment and medication (list all medications and dosages)

Details of the impact of your health condition on your work performance. List the work duties which you are able to perform

List the work duties which you are not able to perform

Describe specific difficulties you are experiencing in performing your duties

When will you be able to return to your present job? Full-time | | Part-time | |

If not able to resume your present job, what alternative jobs could you perform in the company?

Detail any alternative jobs (within or outside the Company or in self-employment) you have performed before or after you became ill/injured

Detail any other jobs or income producing activities you may be able to perform in future

DETAILS OF IMPACT OF YOUR HEALTH CONDITION OF OTHER FUNCTIONS
DESCRIBE THE PRACTICAL IMPLICATIONS OF YOUR ILLNESS/ INJURY ON THE FOLLOWING ACTIVITIES OF DAILY LIVING

Mobility (standing, walking, sitting, bending, carrying etc.)

Self-care (eating, dressing, bathing etc.)

Home management (domestic chores, gardening, shopping, home maintenance, etc.)

Transport (driving, use of public transport, etc.)

Sport and recreational activities

Other

DETAILS OF OTHER INCOME / COMPENSATION

Have you received /are you receiving /do you expect to receive any benefit, salary or income from other sources, such as insurance companies, pension, provident or retirement, any state fund, compensation for occupational injuries and diseases, a business venture or any other source?

Source	Amount	Date of Payment	Expected Period of Payment

AUTHORISATION AND DECLARATION

AUTHORISATION

I hereby authorise my medical practitioner, the Superintendent of the medical institution, or any other person from whom I have received medical, homeopathic or other treatment, alternatively any department who possesses such medical record to release such medical records and to furnish the said records or copies thereof to Salt Employee Benefits and the Insurer.

I acknowledge and understand that the medical records may certain confidential information regarding both my physical and / or mental health.

I hereby authorise Salt Employee Benefits and the Insurer to furnish any information contained in medical reports or otherwise obtained during the course of the assessment of my claim to any health professional which may require such information to assist Salt Employee Benefits and the Insurer in the assessment of my claim.

DECLARATION

I hereby declare and confirm that the answers given by me or the information disclosed in this form are complete in all respects, are both true and correct (whether in my handwriting or not) and that no material information has been withheld nor has any relevant information regarding my physical and/or mental health been omitted, either intentionally or negligently.

Signature of the claimant or of the person completing the form if the claimant is unable to do so

Date

Full Name/s (If not claimant)

Contact Number

Relationship to Claimant

PART THREE: CONFIDENTIAL MEDICAL REPORT

An application for a disability benefit has been submitted by one of your patients. Your completion of this report is required in order to assist in the assessment of this claim. Please also attach copies of any medical reports or results of investigations to substantiate the medical condition(s) of your patient. Any cost in connection with this report will be for the member's account.

Name of Patient	Date of Birth
Employer Name	Occupation
Date of first consultation	Date of last consultation
Height of patient	Weight of patient

Main diagnosis and cause of disablement

Detail the onset and history of the illness/injury

Concurrent conditions

PLEASE GIVE DETAILS OF YOUR CONSULTATIONS WITH THE PATIENT OVER THE LAST 2 (TWO) YEARS

Date	Complaint	Treatment	Response

Details of the last clinical evaluation

Detail objective findings, such as blood tests, x-ray reports, ECG's, echocardiographs and histology reports

Please comment on the nature and extent of any functional impairment related to the illness/injury

Does the patient's work duties and/or environments aggravate the illness or injury	YES	NO

If YES, please describe below

PLEASE PROVIDE DETAILS OF OTHER MEDICAL PRACTITIONERS CONSULTED OR OF HOSPITAL ADMISSIONS OVER THE PAST 3 (THREE) YEARS

Date	Medical Practitioner/ Hospital	Specialty	Treatment/Surgery

Please provide details of present treatment, include medication and dosages, rehabilitation, counselling etc.

If applicable, please detail any complications or side effects of treatment

Please comment on the patient's response and compliance to current treatment

What further medical treatment, procedures or investigations would you recommend?

What further rehabilitation is envisaged for the patient?

Prognosis

When was the claimant last able to perform his/her job?

If the patient is temporarily unable to perform his/her occupational duties, when do you expect the patient to be able to perform his/her occupational duties?

Some duties

All duties

If the patient is permanently unable to perform his/her occupational duties, please comment on other types of work he/she may be capable of performing

Other comments or any additional information which will assist in the assessment of this claim

Signature of Medical Attendant

Name

Date

Contact Number

Qualifications/Specialty

Address