momentum
corporate

Accidental disability claim - employer / employee declaration

Employer and employee to complete this form

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

This declaration will form the basis on which the 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 being declined.

Please attach the following:
- Copy of payslip as at date of accidental disability.
- Copy of employer issued job description.

We will also require the Accidental Disability Claim Confidential Medical Report and copies of all relevant clinical investigation findings and/or surgery reports in order to assess this claim.

Completed form together with supporting documents to be faxed to 021 917 3711 or emailed to wcc@momentum.co.za or posted to PO Box 2212, Bellville, 7535, attention Momentum Group Insurance disability claims.

1. Scheme details

Scheme name	
Employer name	

2. Member details

Title		Initials	
First name/s			
Surname			
Date of birth	D D - M M - Y Y Y Y		
RSA ID	Yes ☐ No ☐	ID/Passport No.	
Passport country of origin			
Gender	Male ☐ Female ☐		
Marital status	Married ☐ Single ☐ Divorced ☐ Widowed ☐		
Home language			
Telephone - work		Fax	
Telephone - home		Cell	
Email			
Residential address			
		Postal code	
Postal address			
		Postal code	
Income tax office		Income tax number	
Medical aid name		Medical aid number	
Date employment commenced	D D - M M - Y Y Y Y	Date of joining disability scheme	D D - M M - Y Y Y Y
Company/employee No			
Gross annual income	R		

3. Employer details

Contact person at company			
Designation			
Telephone		Fax	
Email			
Company address (head office)			
		Postal code	
Company address (office/ branch where member worked)			
		Postal code	

4. Details of occupation (Note - a job description must be attached)

Occupation/Job title

Details of duties. List FIVE main performance areas with a brief description of each.

1.

2.

3.

4.

5.

5. Details of employment history

Apart from your present occupation, please supply a brief employment history, including previous positions held at current and previous employers.

Date started	Date ended	Company	Position held	Type of work	Salary at date of leaving	Reason for leaving

6. Qualifications, training and experience

	Year achieved	Standard/Qualification
Highest level of schooling		
Technical qualifications (NTC, diplomas, etc.)		
Academic qualifications (e.g. degrees, etc.)		
Other training (e.g. certificates,in-house training, driver's licences & codes)		

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

7. Details of accident or event causing injury

Date of accident/event D D - M M - Y Y Y Y Time of accident/event H H - M M

Place of accident/event

Detailed account of the accident/event and resultant injuries.

SAP case number (if applicable)

8. Medical practitioner details

Please give the name, address and tel number of your regular family doctor/general practitioner.

Name

Address

Postal code

Tel No.

Since when has he/she been your family doctor? D D - M M - Y Y Y Y

When was your last consultation? D D - M M - Y Y Y Y

If you have changed general practitioners in the last two years, please give details of all previous attending practitoners.

Name	1st consult date	Last consult date	Tel no.	Hospital/Address	Patient No.

Please give the names and contact details of all medical practitioners consulted in connection with your current illness/impairment.

Name	Speciality	Hospital/address	Tel no.	Condition treated	Patient No.

Details of any hospitalisations within the last two years.

Name of hospital	Admission date	Discharge date	Reason for admission	Surgery performed

9. Banking details

To whom must benefit be paid? Employer ☐ Member ☐ Fund ☐

Name of account holder

Name of bank

Account number Branch no.

Account type Current/cheque ☐ savings ☐ transmission ☐

10. Supporting documents required

A copy of job description is attached Yes ☐ No ☐

A copy of payslip is attached Yes ☐ No ☐

11. Declaration by employer

I hereby declare that all particulars furnished in this form and accompanying documents are true and correct and that no material information has been withheld or omitted. I authorise Momentum to disclose this information to any other party whose opinion is required for the assessment of the claim.

Name of person completing this form	
Designation	
Telephone	
Email	

Signature of Employer

D D - M M - Y Y Y Y

Date

12. Member's declaration and consent to collect and share personal and health information

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 understand that any false and/or misrepresentation of information could be used as a basis for the claim being declined.

Consent to collect and share personal, medical and health information

Momentum will require the collection of personal, medical and health information in order to assess your disability claim. Momentum will therefore have or come into possession of personal, medical and health related information obtained as a result of your disability claim. It may be that third parties are assisting you with your claim and are liaising with Momentum in relation to your claim.

I hereby consent and authorise:

- any health practitioner (e.g. medical practitioner, dentist, occupational therapist, psychologist, etc.), allied health practitioner, hospital, medical aid, employer, insurance company, health risk management service provider appointed by my employer or any other person who has information about my health, employment related activities and personal information, to provide such information to Momentum or any 3rd party nominated by Momentum who requires this information for the purposes of assessing and managing my claim.
- Momentum to furnish any medical, occupational and personal information contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, to a health practitioner, allied health practitioner, health risk management service provider appointed by my employer, or any 3rd party nominated by Momentum who may require such information for the purpose of assisting Momentum in the assessment and management of my claim or for assessing the payment of a benefit provided for in a risk policy where I am the policyholder.
- Momentum to furnish my employer or its duly appointed intermediary with regular claims status reports which will contain personal information. Momentum will not share any health related information in the status reports unless I have given express written consent.
- Momentum to share all medical and health related information (special personal information) with the following third parties:

☐ Employer (including employer representatives) involved with my claim

☐ Financial Advisers and Intermediaries appointed by my employer or myself

☐ Any other person/s appointed by me in writing

☐ All of the above

☐ None of the above

Momentum will share medical and health related information with third parties at its sole discretion. I hereby confirm that I will not hold Momentum, its employees, directors, agents, assigns liable in any manner whatsoever and I hereby indemnify and hold Momentum harmless for the sharing of health related information in terms of this consent.

I hereby confirm that I know and understand this consent I am providing to Momentum herein and that I am doing so of my own free will.

Signature of Member

D D - M M - Y Y Y Y

Date

Options to sign the form:

1. Print out the form, sign and scan it and send it back via email to wcc@momentum.co.za , fax it to Fax +27 (0)21 917 3711 or posted to PO Box 2212, Bellville 7535, attention Momentum Group Insurance disability claims.
2. Place your scanned signature in the signature block by following the steps outlined below.
   - Store your scanned signature as a PDF document in a safe place on your computer.
   - Select the 'comments' tab from your menu in Adobe.
   - Select the 'add stamp' icon.
   - Select custom stamps.
   - Create custom stamps.
   - You can now browse and upload your signature to save it as a custom stamp under 'sign here' in Adobe.
   - You can now go back to your 'stamps' icon and select 'sign here' and select your saved signature.
   - Place it in the document and save the document.

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