momentum
corporate

Disability claim - employer declaration

Employer to complete this form

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

The information requested on this declaration is required and 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. Omission or 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 disability.
- Copy of the member's employer issued job description.
- Copy of the member's leave records for the 2 year period preceding their date of disability.

We will also require the Disability Claim - Employee Declaration, Disability Claim - Confidential Medical Report and copies of all relevant clinical investigation findings 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			
Date joined company	D D - M M - Y Y Y Y		
Date joined scheme	D D - M M - Y Y Y Y		
Company/employee No.			

3. Employer details

Contact person at the company			
Designation			
Tel No.		Fax	
Email			
Address (Head office)			
		Postal code	
Address (office/branch where member worked			
		Postal code	

4. Reason for notification

Reason for notification (Please tick ☑ the appropriate criteria)

Absenteeism

- ☐ Absent from work for 10 consecutive days.
- ☐ Absent from work for five days (consecutive or non-consecutive) in any 30-day period, without medical evidence or notifying the company.
- ☐ Consistently absent on Fridays and/or Mondays, or both.
- ☐ Consistently absent for one or more days per month.
- ☐ Total absence of 20 days or more in any one year.

Productivity Loss

- ☐ Marked loss of productivity due to physical and/or psychological conditions.

Injury

- ☐ Injury on duty requiring treatment, hospitalisation or absence from work.
- ☐ Injury off-site requiring treatment, hospitalisation or absence from work.

Impairment

- ☐ Employee complaint of disability/impairment/difficulty in meeting work requirements.
- ☐ Employee declared disabled / unfit for work by treating doctor.
- ☐ Employee has medical condition requiring treatment, hospitalisation or absence from work.

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

a. Occupation/Job title

Occupation/Job title _____

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

1. _____

2. _____

3. _____

4. _____

5. _____

Is the member responsible for the supervision of any staff? Yes ☐ No ☐

If Yes, number of staff supervised ☐

Normal working hours of job per week ☐ hours

Normal working days of job per week _____

b. Work environment

What percentage of the working day does the member work:

Indoors ___ %

Outdoors ___ %

At heights ___ %

At depths ___ %

Temperature range in place of work ___ to ___ Degrees centigrade

Decibel range in place of work ___ to ___ decibels

Is the member exposed to any dust while working? Yes ☐ No ☐
If Yes, please state the type of dust the member is exposed to.

Is the member exposed to any fumes while working? Yes ☐ No ☐
If Yes, please list all fumes the member is exposed to.

Please give details of any known safety hazards in the member's job.

c. Physical demands

Does the member's job involve any of the following?

Lifting weights	Yes ☐	No ☐	Range of weights lifted	___ to ___ kg
Carrying weights	Yes ☐	No ☐	Range of weights carried	___ to ___ kg
Pushing weights	Yes ☐	No ☐	Range of weights pushed	___ to ___ kg
Pulling weights	Yes ☐	No ☐	Range of weights pulled	___ to ___ kg

Does the member's job involve any climbing? Yes ☐ No ☐
If Yes, indicate what type of climbing (e.g. stairs, ladders, scaffolding) and frequency.

Please indicate how much time is spent on the following activities during each working day. Tick the relevant column and indicate duration.

	Never	Sometimes	Often	Always	**Hours per day**
Sitting	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	
Standing	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	
Walking on even terrain	☐	☐	☐	☐	
Walking on uneven terrain	☐	☐	☐	☐	
Use of both hands	☐	☐	☐	☐	
Use of fine coordination	☐	☐	☐	☐	
Engaging in physical labour	☐	☐	☐	☐	
Reaching above shoulder height	☐	☐	☐	☐	
Reaching below shoulder height	☐	☐	☐	☐	
Working in cramped conditions	☐	☐	☐	☐	

Where the member's job involves manual/physical labour, please specify the tasks involved.

Please list items used in the course of the member's work.

Equipment used

Tools used

Materials used

Machinery used

d. Driving

Only complete this section if driving is a component of the member's job.

Licence code/s required _____

Type of vehicle/s driven _____

Average distance driven

Per day		km
Per week		km
Per month		km

e. Flying

Only complete this section if flying is a component of the member's job.

Type of aeroplane flown _____

Average distance flown per week		km
Average number of hours flown per week		hours

f. Cognitive demands

Please indicate how much of the member's job requires the following abilities during each working day. Tick the relevant column and indicate duration.

	Never	Sometimes	Often	Continuously	**Hours per day**
Concentration					
Memory					
Planning					
Problem solving					
Decision making					
Administration / Clerical tasks					
Calculations / Working with figures					

g. Communication demands

Please indicate how much of the member's job requires the following abilities during each working day. Tick the relevant column.

	Never	Sometimes	Often	Continuously	**Hours per day**
One-to-one communication					
One-to-group communication					
Verbal communication					
Written communication					
Communication with colleagues					
Communication with clients					

6. Details of employment history

Please indicate the member's full employment history at current employer, from the most recent to the earliest position.

	Most recent	Previous	Earlier Position
Date started			
Job title			
Broad description of work done			
Date ceased			
Salary at date of cessation			
Reason for cessation			

7. Salary details

Please provide full details of the member's salary history over the last two years. If the member has worked for the employer for less than two years, please indicate the salary history from the date of appointment.

Date				
Amount of increase				
New salary				
Frequency paid (weekly / monthly / annually)				
Reason for change (annual increase, annual bonus, promotion)				
Estimated amount of additional earnings through overtime, commissions etc.				
Date ceased				

Please advise the member's gross annual income as at the month in which they were last able to perform their normal full time duties.

8. Other compensation

Please list any other sources of compensation the member may receive as a result of disability.

Current or expected future income			
Source of income e.g. employer, self employment, other insurer, UIF, workmans compensation etc.			
Amount of income	R	R	R
How payable (monthly, lump sum)			
Date of commencement of payment			
Policy number/s (if applicable)			

9. Details of disablement

When did the illness first become evident or the injury occur? D D - M M - Y Y Y Y

Last day actively able to perform normal full time duties of own occupation? D D - M M - Y Y Y Y

Last day physically at work? D D - M M - Y Y Y Y

Was the member in active full-time and permanent employment on the last day of work? Yes ☐ No ☐

If No, please give details.

Was the member placed into another position prior to claiming for disability? Yes ☐ No ☐

If Yes, please give details including job title and duties of the position, date started in this position, date ceased in this position and reason for member being placed in this position.

Was the member's normal occupation changed in any way prior to claiming for disability? Yes ☐ No ☐

If Yes, please give a detailed description of changes made, dates on which these changes were made and reasons for changes being made.

Details of any attempts and efforts made to adapt the member's work environment to accommodate their impairment/s.

Which aspects of the member's most recent job is he/she unable to do and why?

If the member has been subject to any particular pressures, either at work or outside of work, please comment on these.

Can the member be placed in another/alternative occupation? Yes ☐ No ☐

If No, please state why not.

If Yes, please give details of possible alternatives.

Has the impairment/disability affected the member's salary? Yes ☐ No ☐

When did he/she last receive a full salary? D D - M M - Y Y Y Y

Has the member's salary been reduced? Yes ☐ No ☐

If Yes, from what date? D D - M M - Y Y Y Y

If Yes, please indicate new, reduced, monthly salary R

Date on which member returned to work (if they have already returned after disability) D D - M M - Y Y Y Y

Date on which member is expected to return to work (if they have not yet returned to work) D D - M M - Y Y Y Y

10. 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	

11. Supporting documents required

I have included the following

Copy of payslip as at date of disability	Yes	No
Copy of job description	Yes	No
Copy of leave records	Yes	No

12. Declaration by employer

I declare that all the information given on this form and accompanying documents is true and correct and that no material information has been witheld. I give Momentum Corporate permission to share this information with any other party who requires this information for the purpose of assisting Momentum Corporate in the assessment and management of this claim.

I declare that I have the necessary authority to complete and sign this form on behalf of the employer.

Name of person completing this form	
Designation	
Telephone	
Email	

Signature of Employer

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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