momentum

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.

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 disability
- A copy of member's ID/passport
- Copy of the claimant's employer issued job description
- Copy of the claimant'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 Employee Benefits 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 (eg 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 history

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				

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 eg 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. Employer banking details

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 members ID / Passport	Yes	No
Copy of job description	Yes	No
Copy of leave records	Yes	No

12. 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 witheld 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

Tel No. - work

Email address

Signature of Employer

D D - M M - 2 0 Y Y

Date

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