

Disability claim form

To be completed by the claimant

The request for completion of this form in no way constitutes an admission of liability by Capitec Bank.

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

Complete all sections of this form, and ensure that it is signed before submitting it. Failure to do so nullifies the submission of this form.

Attach the following to this form:

- · Copy of ID
- Copy of payslip as at the last day actively at work
- · Job description
- Any medical certificates/medical information that the claimant may have

Delays in submitting this and other required documentation results in delays in finalising the claim. We therefore urge you to complete and submit the claims package as soon as possible.

We will also require the Disability Claim Employer Declaration and Disability Claim Confidential Medical Report with copies of all relevant clinical investigation findings in order to assess this claim.

 $The \ completed \ form, together \ with \ supporting \ documents, \ must \ be \ faxed, \ emailed \ or \ submitted \ to \ a \ Capitec \ Bank \ branch.$

Please note that the form must be completed in full. Do not leave any blank spaces or cross anything out.

-Section 1: Policy noider particulars—		Date of Birth D D M M Y Y Y Y
First Names		
Surname		
ID /Passport Number		Gender: Male Female
Marital Status: Married	Single Divorced	Widowed
Home language		
Residential/Business Address		
		Postal Code
Postal Address		
		Postal Code
Telephone Number (h)	Email/Fax	
Cellphone Number		
Alternative contact name and surname		
Relationship		
Cellphone Number	Email/Fax	

—Section 2: Occupation details————				
Date joined company	D D M M Y Y Y			
Date when you started in your current occupation	Date when you started in your current occupation D D M M Y Y Y			
Date when you were last actively able to do this job	D D M M Y Y Y Y			
Have you been able to perform any part of your main	n duties since the commencement of	your health condition?	Yes No	
If Yes, please provide a description				
What is your current employment status?				
Working full time	Working part time			
On paid sick leave	On unpaid leave			
Laid off or retrenched	Under notice of termination o	f service		
What was the date of termination of service	D D M M Y Y Y Y			
—Section 3: Education details				
Trade certificate obtained				
In-house training received				
Highest level of schooling Year	Standard/Grade	School		
Academic qualifications (e.g. degrees), technical qua	alifications (e.g. NTC, diplomas)			
Year	Qualification	Institution		
—Section 4: Employment history—				
Apart from your present occupation, supply a brief jo	ob history, including previous position	ns held.		
Dates Company	Position held	Brief description of work done	Reason for leaving	
D D M M Y Y Y Y				
What other jobs may you be able to do given your qu	Jalifications and work experience?			
When do you expect to return to work?	M Y Y Y			

-Section 5: Details of medical conditions ————————————————————————————————————	
Describe your illness or injury:	
What are the symptoms of your illness or injury?	
When did you first consult a medical practitioner in connection with this condition?	D D M M Y Y Y Y
If your health status has been changed by an illness, when was it first diagnosed?	
	D D M M Y Y Y
How has it been treated?	
Medications Exercise Operation	Other
If other, please specify:	
If your health status has been changed by an injury, provide the date of the injury:	D D M M Y Y Y
Cause of the injury:	
How has it been treated?	
Medications Exercise Operation	Other
Cause of the injury:	
How has the condition affected you in performing your work duties?	
How has your condition affected you in performing your daily tasks, e.g. self-care, home maintenance, ability t	to travel?
What type of transport do you use and has your condition interfered with this?	

-Section 5: Details of n	nedical conditions (cont	inues)—				
If you use private health faci	lities, provide the contact deta	ils for your	treating general pra	actitioner		
Name and Surname						
Address						
Cellphone/Tel			Email/Fax			
Date of Last Consultation w	ith This Doctor					
If you use private health faci	lities, provide the contact deta	ails for your	treating specialist:		D D M M Y Y Y	
Hospital or Clinic						
Telephone	phone					
Name of Doctor						
Your Patient Number						
Date of Last Appointment	D D M M Y Y Y Y		Date of	of Your next Appointme	nt D D M M Y Y Y Y	
Please attach a copy of any i	medical reports or a copy of yo	ur patient fil	le.			
Have you, in the last 5 years	s, suffered from any serious dis	sease, illnes	s or health problem	ns?	Yes No	
If Yes, state the nature of the	e disease, illness or health pro	blem.				
Have you been admitted to h	nospital in the last 2 years?				Yes No	
If Yes, please complete the t	following:					
Date Admitted	Hospital		ng Doctor and tact Number	Reason for Admissi	on Date Discharged	
D D M M Y Y Y						
Please complete if your hea	Ith problem arose from an acc	ident or oth	er violent means:			
Date of Accident	What Type of Accident/Incident Occ			/here Reported	Police Case Number	
D D M M Y Y Y						
Details of any surgery perfo	med in the last year:					
Current treatment: Is any further treatment or operations contemplated? If Yes, provide details:						
List the medication you are on including the dosages.						

Section 5: Details of medical conditions (continues)	
Did any of the following contribute in any way to your disability?	Yes No
Failure to seek timely and adequate medical attention or to heed medical advice given?	Yes No
Consumption of alcohol or taking drugs or narcotics (except under medical direction)	Yes No
Attempted suicide or self-inflicted injury?	Yes No
If you answered Yes to any of these questions, please provide full details of the circumstances:	
Section 6: Employer details	
Name of employer/company	
Contact person	
Cellphone/Tel	
—Section 7: Declaration	
I,being aware of my rights pertaining to privacy of my medical practitioner, hospital, employer or other person to all other parties with any information relating to my illness or injury. I further authorise Capitec Bank to gather informal also hereby authorise Capitec Bank to release the aforementioned information to other parties involved in the claim. that the answers given by me in this claim form are, in every respect, true and correct, and that no material information circumstances omitted.	ofurnish Capitec Bank, insurer and tion regarding my employment. I hereby declare and warrant
Signed at:	
Signature:	D D M M Y Y Y Y