Credit Insurance Disability Claim Form
Claimant Declaration

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. Misrepresentation of information could be used as a basis for the claim being declined.

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 proof of income as at the date of disability
- 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 emailed to **insuranceclaims@capitec.com** or submitted to a Capitec Bank branch.

If you are NOT formally employed, do not complete the sections/ questions indicated with an asterisk *
Please note that the form must be completed in full. Do not leave any blank spaces or cross anything out.

Section 1: Insured 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

Cellphone number

Alternative contact name and surname

Relationship

Cellphone number

Email

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T1-S1-001 Disability Claim Form Employee Declaration

Section 2: Occupation details*

Date joined company D D M M Y Y Y Y

Date when you started in your current occupation D D M M Y 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 duties since the start 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 of service ☐

What was the date of termination of service? D D M M Y Y Y Y

Section 3: Education details*

Highest level of schooling

Year Completed	Standard/Grade	School

Academic qualifications (e.g. degrees), technical qualifications (e.g. NTC, diplomas)

Year Completed	Qualification	Institution

Trade certificate obtained

In-house training received

Section 4: Employment history*

Apart from your present occupation, supply a brief job history, including previous positions held.

Dates	Company	Position held	Reason for leaving
D D M M Y Y Y Y			

What other jobs may you be able to do given your qualifications and work experience?

When do you expect to return to work? D D M M Y Y Y Y

Section 5: Details of medical conditions

Describe 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

What are the symptoms of your illness or injury?

When were you first diagnosed with your illness/injury?

D D M M Y Y Y Y

If your condition is related to an injury, please detail the cause of your injury :

How has your condition been treated?

Medications ☐ Exercise ☐ Operation ☐ Other ☐

If other, please specify:

List the medication you are on including the dosages.

How has the condition affected you in performing your work duties?

How has your condition affected you in performing your daily activities ? Please tick the appropriate response

Activity	Able to perform	With some assistance	Not able
Bathing	No assistance required ☐	You are able to bath yourself, but need some assistance. Hands-on assistance is required or; Assistive devices, such as handrails, bath bench is required. ☐	You are totally dependant on others in all areas of bathing ☐
Grooming	No assistance required ☐	Hands-on assistance is required with some activities when grooming yourself ☐	You are totally dependant on others in all areas of grooming ☐
Dressing	No assistance required ☐	Hands-on assistance is needed with some activities. ☐	You are totally dependant on others in all areas of dressing ☐
Eating and Feeding	No assistance required ☐	Hands-on assistance is required, e.g. help with cutting up food or pushing food within reach, or help with applying an assistive device. ☐	You are totally dependant on others in all areas of eating and feeding ☐
Toileting	No assistance required ☐	Hands-on assistance is required with some activities, e.g. transferring onto the toilet. ☐	You are totally dependant on others in all areas of toileting. You have no bladder control. Permanent catheter or Permanent colostomy ☐
Mobility in home	No assistance required ☐	Walking and transferring requires the assistance of another person, or a railing, cane, walker or wheelchair ☐	You are totally dependant on others to assist you with walking or transferring ☐

Section 5: Details of medical conditions (continued)

Please comment on your ability to carry out the specified activities in the table below:

Functional activities	Able	With some assistance	Unable	Comments
Use of right hand				
Use of left hand				
Lifting				
Carrying				
Standing				
Sitting				
Bending				
Walking				

If you use private health facilities, provide the contact details for your treating general practitioner

Name and Surname

Address

Cellphone/Tel

Email/Fax

Date of last consultation with this doctor

D D M M Y Y Y Y

Date of your next appointment

D D M M Y Y Y Y

Please attach a copy of any medical reports or a copy of your patient file

Have you been admitted to hospital in the last 2 years? Yes No

Date Admitted	Hospital	Treating Doctor and Contact Number	Reason for Admission	Date Discharged
D D M M Y Y Y Y				

Details of any surgery performed in the last year:

Provide details of any further treatment or operations contemplated or planned:

Section 6: Other insurance

Have you submitted a claim to any other insurance company Yes ☐ No ☐

If yes please provide us with the following details:

Insurer name

Insurer contact number

Contact person

Section 7: Employer details

Name of employer/ company

Contact person

Cellphone/Telephone number

Section 8: Declaration

I, ……., ID……..„being aware of my rights pertaining to privacy of my medical records and or information, do hereby give my informed consent and hereby authorise any medical practitioner, hospital, employer or other person to furnish Capitec Bank, insurer and all other parties with any information relating to my illness or injury. I further authorise Capitec Bank to gather information regarding my employment.

I also hereby authorise Capitec Bank to release the aforementioned information to other parties involved in the claim. I hereby declare and warrant that the answers given by me in this claim form are, in every respect, true and correct, and that no material information has been withheld nor relevant circumstances omitted.

Signed at: _____

Signature: _____

D D M M Y Y Y Y

Processing of Personal Information in terms of the Protection of Personal Information Act 4 of 2013

Processing of Personal Information in terms of the Protection of Personal Information Act 4 of 2013. The privacy of our Insured is of utmost importance to us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

The Insured's Personal Information will be used to assess the claim for the Insured. You hereby agree to give honest, accurate and up-to-date Personal Information of our Insured to assist us in assessing the risk insured against.

You acknowledge that any Personal Information supplied to us in respect of the Insured is provided according to the Applicable Laws. Unless consented to by yourself, we will not sell, exchange, transfer, rent or otherwise make available any Personal Information you have provided in respect of our Insured unless it is a requirement in terms of the Applicable Laws.