

Eis vir Enkelbedragongeskiktheidsvoordeel en/of maandelikse ongeskiktheidsinkomste-voordeel

Claim for Lump sum disability benefit and/or monthly disability income benefit

1 Inhoud / Contents

Die volgende vorms moet voltooi word met die indiening van 'n eis vir 'n ongeskiktheidsvoordeel.
The following forms must be completed for the submission of a claim for a disability benefit.

- **Verklaring deur fonds/skema** – *Moet deur die werkgewer voltooi word.*
 - **Declaration by fund/scheme** - *To be completed by employer.*
- **Verklaring deur versekerde** – *Moet deur die versekerde voltooi word.*
 - **Statement by insured** – *To be completed by the insured.*
- **Vertroulike mediese verslag** – *Die verslag moet deur die versekerde se behandelende spesialis opgestel word volgens aangehegte "Riglyne vir mediese verslag oor funksionele inkorting". (Sien bladsy 15).*
 - **Confidential medical report** - *Report to be compiled by insured's treating specialist according to the "Guidelines medical report on functional impairment" attached. (See page 16).*
- **Siekteverlofrekords** – *Voorsien afskrifte van siekteverlofrekords vir die afgelope 12 maande.*
- **Sick leave records** – *Provide copies of all sick leave records for the past 12 months.*

Belangrik: *Indien daar bestaande spesialisverslae beskikbaar is moet afdrukke daarvan asseblief saam met die eis-dokumente gestuur word.*

Important: *If there are any existing specialist reports available please forward copies with the claim documents.*

2 Algemeen / General

- Die versekerde moet die aanvanklike medies en ander dokumente ter staving van sy/haar ongeskiktheid betaal. Dit is die versekerde se verantwoordelikheid om sy ongeskiktheid te bewys in terme van die kontrakbepalings.
 - The insured has the initial responsibility of providing medical and other documentary evidence of disability at his/her own cost. It is the insured's responsibility to prove that he/she is disabled in terms of the policy provisions.
- Die versekerde is verplig om enige medies of ander inligting wat Sanlam redelikerwys nodig mag ag, te lewer.
 - The insured is obliged to submit whatever medical or other information Sanlam may reasonably require.
- Die versekerde moet ook chirurgie of enige ander mediese behandeling wat redelikerwys van hom/haar verwag kan word, ondergaan.
 - The insured should undergo surgery or any other medical treatment which can reasonably be expected from him/her to undergo.

Die werkgewer moet asseblief die volledig voltooide vorms pos, faks of e-pos aan:

Sanlam Groep Risiko Voordele: Ongeskiktheidseise (7709)
Posbus 1
Sanlamhof
Bellville
7532

Faksnommer (021)947-3207
E-pos adres Disabilityclaimbenefits.EB@sanlam.co.za

The employer must please either post, fax or e-mail the duly completed forms to:

Sanlam Group Risk Benefits: Disability Claims (7709)
PO Box 1
Sanlamhof
Bellville
7532

Fax number (021)947-3207
E-mail address Disabilityclaimbenefits.EB@sanlam.co.za

Verklaring deur fonds/skema Declaration by fund/scheme

A. Besonderhede van fonds/skema Particulars of fund/scheme

Naam van fonds/skema _____ Kode _____
Name of fund/scheme _____ Code _____

Naam van deelnemende tak/werkgewer _____
Name of branch/participating employer _____

E-posadres _____
E-mail address _____

Telefoonnommer _____
Telephone number () _____

B. Persoonlike besonderhede van versekerde Personal details of the insured

Volle voorname en van _____
Full names and surname _____

Geboortedatum _____ (dd/mm/eejj) _____ Geslag: Manlik _____ Vroulik _____
Date of birth _____ (dd/mm/ccyy) _____ Gender: Male Female

Huwelikstaat: Enkel Getroud Geskei Woon saam Weduwee/Wewenaar
Marital status Single Married Divorced Co-habiting Widowed

Identiteitsnommer _____
Identity number _____

Besonderhede van lidmaatskap Particulars of membership

Lidmaatskapnr. _____ Betaalstaatnr. (Indien enige) _____
Membership no. _____ Pay-sheet no. (if any) _____

Datum van diensaanvaarding _____ Datum van vaste aanstelling _____
Date of entering service _____ Date of permanent appointment _____

Aanvangsdatum van lidmaatskap _____
Date of commencement of membership _____

Indien skema minder as een jaar deur Sanlam onderskryf is, voltooi die volgende:
If the scheme has been underwritten by Sanlam less than one year, please complete the following:

Tipe voordeel en bedrag dekking wat versekerde geniet het by vorige versekeraar.
Type of benefit and cover the insured enjoyed at previous insurer.

Tipe voordeel _____ Bedrag dekking _____
Type of benefit _____ Amount cover R _____

Sedert watter datum het versekerde dekking geniet by vorige versekeraar?
Provide the date from when the insured received cover at previous insurer? _____

Jaarlikse pensioengewende besoldiging van versekerde vir die afgelope 24 maande:
Annual pensionable remuneration of insured for the past 24 months:

Datum salaris toegestaan Date salary received	Jaarlikse salaris (R) Annual salary (R)

Besonderhede van lidmaatskap (vervolg)**Particulars of membership (continue)**

Vesekerde bedrag ten opsigte van ongeskiktheid

Sum assured in respect of disability

R _____

Datum van laaste aftrekking van lidbydraes

Date of last deduction of insured's contribution

____ / ____ / _____

(dd/mm/eejj)

(dd/mm/ccyy)

Werkgewerbydraes ten opsigte van die versekerde is/word betaal tot

Employer's contributions in respect of the insured was paid/will be paid up to

____ / ____ / _____

Besonderhede van versekerde se beroep en alternatiewe beroepe**Particulars of insured's occupation and alternative occupations****Nota:** Hierdie gedeelte moet in oorleg met die versekerde se onmiddellike hoof, toesighouer of deur enige iemand anders wat van die omstandighede kennis dra, ingevul word.**Note:** This section must be completed in consultation with the insured's immediate superior, overseer or by any other person who is conversant with the circumstances.

Beroep voor ongeskiktheid

Occupation before disablement _____

Naam van toesighouer

Name of supervisor _____

Telefoonnommer van toesighouer

Telephone number of supervisor

(____) _____

Naam van kontakpersoon by Menslike Hulpbronne-afdeling

Name of contact person at Human Resources Department _____

Telefoonnommer van kontakpersoon

Telephone number of contact person

(____) _____

Laaste datum waarop hy/sy gewerk het

Last date of performing his/her duties

____ / ____ / _____

(dd/mm/eejj)

(dd/mm/ccyy)

Het hy/sy enige ander werk na bogenoemde datum gedoen?

Did he/she do other work thereafter?

Ja

Yes

Nee

No

Indien 'Ja', verstrek die volgende besonderhede:

If 'Yes', provide the following particulars:

In watter kapasiteit?

In which capacity? _____

Werksbeskrywing

Description of work _____

Vanaf watter datum?

From which date? ____ / ____ / _____

Tot watter datum?

Until which date? ____ / ____ / _____

- Was die versekerde afwesig gedurende die 12 maande onmiddellik voor ongeskiktheid?

Was insured absent from service in the 12 months immediately before disability?

Ja

Yes

Nee

No

Indien 'Ja', verstrek die volledige besonderhede:

If 'Yes', provide the full particulars:

Vanaf datum / From date	Tot datum / To date	Redes (sieketoestand) / Reasons (disease)

- Opvoedkundige kwalifikasies van versekerde.

Educational qualification of insured. _____

- Opvoedkundige kwalifikasies/opleiding/ondervinding vereis vir beroep voor ongeskiktheid.

Educational qualifications/training/experience required for occupation before disability. _____

Besonderhede van versekerde se beroep en alternatiewe beroepe (vervolg)
Particulars of insured's occupation and alternative occupations (continue)

Is die versekerde vir 'n pos elders in die onderneming oorweeg? Ja Nee
Was the insured considered for any other position in the organisation? Yes No

Indien "Ja" beantwoord asseblief die volgende vrae.
If 'Yes', please answer the following questions.

In watter hoedanigheid was dit?
In what capacity? _____

Is die pos in status Hoër Gelyk Laer as vorige posisie
Is the position Higher Equal Lower to the previous position

Indien u antwoord in die vorige paragraaf "Laer" is, verstrek asseblief redes waarom 'n laer graad pos die versekerde aangebied is (bv. as gevolg van graad van ongeskiktheid nie gekwalifiseer vir hoër graad pos nie, geen hoër graad pos was beskikbaar, ens.).

If you answered "lower" in the previous paragraph, please give reasons why the insured was offered a lower grade position (e.g. as a result of the degree of disability he/she no longer qualified for higher grade post, no higher grade post was available, etc.).

Gemiddelde vergoeding per maand in hierdie pos:

Average remuneration per month in this position: _____

Het die versekerde die pos aanvaar?

Did the insured accept the position? _____

Indien nie, verstrek asseblief redes:

If not, please provide reasons: _____

Indien versekerde nie elders oorweeg/geplaas kan word nie, verstrek asseblief redes:

If insured could not be consider/placed elsewhere, please give reasons: _____

Versekerde se beroepsbesonderhede
Details regarding the insured's occupation

Pos deur die versekerde bekleed.
Position held by insured. _____

Wanneer laas was die versekerde bevoeg om sy beroep te beoefen? (dd/mm/eejj)
When was the insured last able to do his own occupation? _____ / _____ / _____ dd/mm/ccyy

Dui aan in watter werkskategorie die versekerde val. (Merk asseblief die toepaslike opsie met 'n X)
What was the insured's job category? (Please mark the most applicable with an X)

- | | |
|---|--|
| <input type="checkbox"/> Bestuurder
Managerial | <input type="checkbox"/> Masjien operateur (bv. bestuur van of gebruik van masjien om taak te verrig)
Machine operator (eg. driving or using a machine to perform the task) |
| <input type="checkbox"/> Toesighouer
Supervisor | <input type="checkbox"/> Ligte hande arbeid (bv. fisiese verpakking en sortering)
Light manual labour (eg. physically packing or sorting) |
| <input type="checkbox"/> Klerklik
Clerical | <input type="checkbox"/> Swaar hande arbeid (bv. fisiese grawe of op laai)
Heavy manual labour (eg. physically digging or loading) |
| <input type="checkbox"/> Ander (spesifiseer)
Other (specify) _____ | |

Bestuur van voertuie
Driving a vehicle(s)

Tipe voertuig of voertuie:
Type of vehicle or vehicles: _____

Tipe terrein waarop voertuig bestuur word:
Type of terrain where vehicle is driven: _____

Skatting van afstand, in kilometers, wat oor 'n spesifieke periode bv. per dag/per week/per maand, afgelê word.
Estimate distance, in kilometres, covered over a specific period, e.g. per day/per week/per month.

Versekerde se beroepsbesonderhede (vervolg)

Details regarding the insured's occupation (continue)

Dui asseblief die versekerde se hoof pligte aan:

Please list the insured's main duties:

Plig / Duty	Gewig / Weight (%)	Vermoë om 'n taak te verrig / Ability to perform		
		Bekwaam / Able	Gedeeltelik bekwaam / Partially able	Onbekwaam / Unable
	100%			

(Vul asseblief die nodige inligting in en merk die toepaslike opsie met 'n X)

(Complete the necessary details and mark the applicable option with an X)

Werkvereiste Job demands	%	Frekwensie per dag Frequency per day	%	Maksimum gewig gemanipuleerd / Maximum weight manipulated	Gereeld Frequent	Per geleentheid Occasional
Fisies / Physical		Stap / Walking		4.5kg		
		Staande / Standing		9kg		
		Sittende / Sitting		22kg		
		Klim / Climbing		45kg		
		Gebukkend / Stooping		+45kg		
			100%			

Werkvereiste Job demands	%	Frekwensie per dag Frequency per day	%	Maksimum gewig gemanipuleerd / Maximum weight manipulated	Gereeld Frequent	Per geleentheid Occasional
Toesighoudend / Supervisory		Stap / Walking		4.5kg		
		Staande / Standing		9kg		
		Sittende / Sitting		22kg		
				45kg		
				+45kg		
			100%			

Werkvereiste Job demands	%	Frekwensie per dag Frequency per day	%	Take / Tasks	Gereeld Frequent	Per geleentheid Occasional
Administratief / Administrative		Stap / Walking		Liassering / Filing		
		Staande / Standing		Tikwerk / Typing		
		Sittende / Sitting		Telefoon hantering / Telephone use		
				Vergaderings / Meetings		
	100%		100%			

Versekerde se beroepsbesonderhede (vervolg)
Details regarding the insured's occupation (continue)

Beskryf die minimum vermoë wat 'n gesonde individu moet hê om die werk te verrig.
 Please describe the minimum abilities that a healthy individual requires to do this job.

	Vlak van vermoë / Level of ability		
	Ongeskool / Unskilled	Geskool / Skilled	Professioneel / Professional
Geletterd / Literacy			
Syferkennis / Numeracy			
Geheue / Memory			
Probleem oplossing/redenering / Problem solving/Reasoning			
Gespesialiseerde kennis / Specialised knowledge			

Beskryf die minimum kommunikasie vaardighede wat 'n gesonde individu moet hê om die werk te verrig.
 Please describe the minimum communication skills that a healthy individual requires to do this job.

	Vlak van vermoë / Level of ability		
	Ongeskool / Unskilled	Geskool / Skilled	Professioneel / Professional
Geletterd / Literacy			
Syferkennis / Numeracy			
Geheue / Memory			
Probleem oplossing/ redenering / Problem solving/Reasoning			
Gespesialiseerde kennis / Specialised knowledge			

Hoe gereeld werk die versekerde in die volgende omstandighede?
 How often does the insured work in the following conditions?

Werkomstandighede / Work conditions	Hoe gereeld? / How often?	Werkomstandighede / Work conditions	Hoe gereeld? / How often?
Binnenshuis / Indoors		Stof / Dust	
Buite / Outdoors		Vibrasie / Vibration	
Hoogtes / Heights		Geraas / Noise	
Ondergrond / Underground		Walms / Fumes	
Nat areas / Wet areas		Uitermatige hitte / Extreme heat	
Koue / Cold storage		Stap op ongelyke oppervlakte / Walking on uneven surfaces	
Klim (trappe/leer) / Climbing (stairs/ladder)		Werk met masjinerie / Operate machinery	
Bestuur: Tipe voertuig / Driving: Type of vehicle		Geskatte afstand afgelê per dag/week/maand / Estimate distance covered per day/week/month	

C. Algemeen

General

- Ontvang die versekerde, of verwag hy/sy om enige voordeel te ontvang, van watter aard ookal, as gevolg van sy/haar ongeskiktheid? (Dit sluit in ontvangstes van die Kommissaris, Pensioenfonds, staatsfonds of enige ander bron.)

Does the insured receive, or expect to receive, any benefits of whatever nature, as a result of his or her disability? (This income includes income from the Commissioner, pension fund, government fund or any other source.)

Ja Nee
Yes No

Indien 'Ja', verstrek asseblief die volgende besonderhede:

If 'Yes', please provide the following details:

Gereelde bedrae / Regular amounts

Bron van voordeel Source of benefit	Bedrag Amount	Aanvangsdatum van betaling Commencement date of payment	Stakingsdatum Cessation date

- Ontvang die versekerde sedert die datum van ongeskiktheid of verminderde besoldiging of geen besoldiging?

Has the insured received either reduced remuneration or no remuneration since disablement?

Ja Nee
Yes No

Indien 'Ja', verskaf besonderhede asseblief.

If 'Yes', please provide details. _____

- Laaste datum waarop versekerde volle besoldiging ontvang het.

Last date on which the insured received full remuneration. _____ / _____ / _____ (dd/mm/eejj)

(dd/mm/eejj)

(dd/mm/ccyy)

Belangrik: Heg asseblief 'n afskrif van die versekerde se identiteitsdokument aan.

Important: Please attach a copy of the insured's identity document.

Ons die ondergetekendes, verklaar namens die fonds/skema dat die inligting hierbo verstrek volledig en korrek is.

We, the undersigned, declare on behalf of the fund/scheme that the information provided above is complete and correct.

Onderteken namens die fonds/skema

Signed on behalf of the fund/scheme

Voorletters en van

Initials and surname _____

Hoedanigheid

Designation _____

Handtekening

Signature _____

Plek

Place _____

Datum

Date _____

(dd/mm/eejj)

(dd/mm/ccyy)

D Mediese Fonds Bydraekwytskeldingsvoordeel / Medical Aid Premium Waiver benefit

Die volgende inligting moet verskaf word as 'n eis vir die Mediese Fonds Bydraekwytskeldingsvoordeel oorweeg moet word tesame met die ongeskiktheid van die versekerde.

The following information must be provided if a claim for the Medical Aid Premium Waiver Benefit must be considered with the disability of the insured.

Naam van versekerde se Mediese Fonds

Name of insured's Medical Aid Scheme _____

Besonderhede van afhanklikes Particulars of dependants	Naam en van Name and surname	Geboortedatum Date of birth	Bedrag van Mediese Fonds premie * Amount of Medical Aid premium *
Hooflid / Principle member			
Gade / Spouse			
Kind / Child (1)			
Kind / Child (2)			
Kind / Child (3)			
Kind / Child (4)			

* insluitend die premie vir spaarrekening en ongebore kind indien swangerskap in die tweede of derde trimester

* including the premium for savings account and unborn child if pregnancy is in second or third trimester

- Is die versekerde 'n lid van die Vitality program? Ja Nee
- Are the insured a member of the Vitality programme? Yes No

Indien "Ja", bevestig die premie

If "Yes", state the premium R _____

- Het die lid enige Gaping dekking? Ja Nee
- Does the insured have GAP cover? Yes No

Indien "Ja", bevestig die premie

If "Yes", state the premium R _____

- Is die bogenoemde voordele ingesluit by die Mediese Fonds premie? Ja Nee
- Are the above included in the Medical Aid Premium? Yes No

Volgens die polis, is die betalings vir die Mediese Fonds Bydraekwytskeldingsvoordeel betaalbaar aan die Werkgewer
According to the policy, payments for the Medical Aid Premium Waiver Benefit are payable to the Employer

Naam van Werkgewer

Name of employer _____

Naam van bank

Name of bank _____

Takkode

Branch code _____

Rekeningnommer van werkgewer

Account number of employer _____

Belangrik: Sanlam moet asseblief in kennis gestel word indien enige van die voorafgaande inligting verander wat betrekking het op die Mediese Fonds Bydraekwytskeldingsvoordeel

Important: Please inform Sanlam if any of the above-mentioned information should change with regards to the Medical Aid Premium Waiver Benefits

Verklaring / Declaration

Ons, die ondergetekendes, verklaar hiermee names die fonds/skema, dat die inligting hierbo verskaf volledig en korrek is.
We, the undersigned, declare on behalf of the fund/scheme, that the information provided above is complete and correct.

Geteken namens die fonds/skema / Signed on behalf of the fund/scheme

Voorletters en van Initials and surname	_____	Voorletters en van Initials and surname	_____
Hoedanigheid Designation	_____	Hoedanigheid Designation	_____
Handtekening Signature	_____	Handtekening Signature	_____
Plek Place	_____	Datum Date	_____ / _____ / _____ (dd/mm/eejj) (dd/mm/ccyy)

Ongeskiktheidseis: Verklaring deur versekerde Disability Claim: Declaration by Insured

Naam van fonds/skema
Name of fund/scheme _____

Naam van versekerde
Name of insured _____

Geboortedatum / Identiteitsnommer
Date of birth / Identity number _____

Lidmaatskapnommer
Membership number _____

Telefoonnommer / Selfoonnommer
Telephone number () / Cell phone number () _____

E-posadres
E-mail address _____

1 Beroepsgeskiedenis Occupational history

- Verskaf asseblief 'n volledige uiteensetting van u loopbaan geskiedenis met inbegrip van u huidige beroep. Die presiese datum(s) waarop diens aanvaar en beëindig is, word verlang:

Please give a detailed description of your career history, including your present occupation. The exact date(s) on which service commenced and was terminated, are required:

Naam en adres van werkgever Name and address of employer	Tydperk indiens / Vanaf / From	Period in service Tot / To	Aard van werk Nature of work

- Beskryf asseblief die kernfunksies van u beroep onmiddellik voor ongeskiktheid.
Please describe the most important functions of your occupation directly before disablement.

- Was u in staat om u eie beroep of enige ander beroep of funksie te verrig sedert u oorspronklik ongeskik geraak het?

Have you been able to perform your own occupation or any other occupation or function since you first became disabled?

Ja Nee
Yes No

Indien 'Ja', verskaf asseblief inligting:

If 'Yes', please give details:

Datum / Date	Titel van beroep / Job title	Vergoeding / Remuneration

- Op watter datum het u laas aktief u gereelde beroep beoefen? _____ (dd/mm/eejj)
On what date did you last actively practise your occupation? _____ (dd/mm/ccyy)

- Opvoedkundige kwalifikasies: Hoogste skool kwalifikasies _____
Educational qualifications: Highest school qualification _____
Ander opleiding/kwalifikasies _____
Other training/qualifications _____

Beroepsgeskiedenis (vervolg)
Occupational history (continue)

- Op grond van u ondervinding en opleiding, watter ander beroepe is u van mening kan u beoefen?
 Based on your experience and training, what other occupations can you perform?

- Wanneer verwag u om in staat te wees om u werk te hervat?
 When do you expect to be able to resume work?

Voltyds _____ Deeltyds _____ (dd/mm/eejj)
 Full time / / Part time / / (dd/mm/ccyy)

2 Aard van ongeskiktheid en mediese sorg
Nature of disability and medical care

- Naam en adres van u gereelde huisdokter. _____ Name _____
 Name and address of your regular family doctor. Name _____
 Adres _____
 Address _____

- Sedert watter datum is hy/sy u huisdokter? _____ (dd/mm/eejj)
 Since what date has he/she been your family doctor? / / (dd/mm/ccyy)

- Datum van die laaste konsultasie. _____ (dd/mm/eejj)
 Date of last consultation. / / (dd/mm/ccyy)

Naam van vorige huisdokter? _____
 Name of previous family doctor? _____

- Watter siekte, besering of afwyking maak u ongeskik om te werk?
 Which illness, injury or impairment causes your inability to work?

- Beskryf asseblief die simptome wat u ondervind en hoe dit u vermoë om te werk beperk.
 Please describe the symptoms that you are experiencing and how they influence your ability to work.

- Sedert watter datum ondervind u die simptome? _____ (dd/mm/eejj)
 Since what date did you experience the symptoms? / / (dd/mm/ccyy)

- Op watter datum het u vir die eerste keer 'n geneesheer hiervoor geraadpleeg?
 On what date did you see a doctor about this for the first time? _____ / /

Wat is die naam van die geneesheer? _____
 What was the name of this doctor? _____

- Verskaf asseblief besonderhede van alle dokters, spesialiste en hospitale wat u geraadpleeg het.
 Please provide the names of all doctors, specialists and hospitals that you have consulted in this regard.

Datum/ Date		Naam van hospitaal of dokter / Name of hospital or doctor	Adres / Address	Telefoonnummer / Telephone number
Vanaf / From	Tot / To			

Aard van ongeskiktheid en mediese sorg (vervolg)

Nature of disability and medical care (continue)

- Hoe bring u tans u dae deur? (Bv. stokperdjies, ens.)
How do you presently spend your days? (Hobbies, etc.)

- Watter aktiwiteite (uitsluitende werkstake) wat u voor u siekte/ongeluk uitgevoer het kan u tans nie uitvoer of ondervind u probleme mee?
Which activities (excluding work tasks) can you not perform or do you experience problems with at present, as a result of your sickness/accident?

- Indien u enigsins belemmer is in die behartiging van u persoonlike belange of in die alledaagse versorging van u persoon, meld asseblief in watter opsig.
If you are at all handicapped in looking after your personal interests or caring for your person, please state in what respect.

- Indien u ongeskiktheid deur 'n ongeluk veroorsaak is, verstrek asseblief die volgende inligting:
If your disability was caused by an accident, please give the following information:

- Omstandighede wat tot die ongeluk aanleiding gegee het.
Circumstances causing the accident.

- As 'n formele ondersoek gehou is, meld asseblief deur wie en wat die uitslag daarvan was.
If a formal enquiry was conducted, please state by whom and what the result was.

- Datum van ongeluk _____ (dd/mm/eejj)
Date of accident _____ / _____ / _____ (dd/mm/ccyy)

3 Inkomste Income

- Het u as gevolg van of tydens u ongeskiktheid enige voordeel, salaris, pensioen of vergoeding van watter aard ook al, ontvang of verwag u om te ontvang? (Insluitend ontvangstes van enige werkgewer, vennoot, versekeringsmaatskappy, 'n pensioen- of uitredings- annuïteitsfonds, enige staatsfonds of van enige ander bron.)

Are you receiving or do you expect to receive, as a result of or during your disability, any benefit, salary, pension or compensation of whatever nature? (Including income from any employer, partner, assurance company, a pension or retirement annuity fund, any governmental fund or any other source.)

Ja Nee
Yes No

- Indien "Ja" verstrek asseblief die volgende besonderhede:
If 'Yes', please give the following details:

Gereelde bedrae (Lyfrentes en jaargelde ingesluit.)
Regular amounts (Including Life annuities.)

Bron van voordeel / Source of benefit	Bedrag / Amount (R)	Aanvangsdatum van betaling / Commencement date of payment	Datum waarop dit gestaak word / Date of cessation

Inkomste (vervolg)
Income (continue)

Ongeskiktheidsbedrae ingesluit by gewone versekering by enige ander maatskappye (Ongeag of eis reeds ingedien is.)
Disability amounts included in ordinary assurance at any other companies (Regardless of whether claim has been submitted already.)

Naam van maatskappy / Name of company	Bedrag / Amount (R)	Datum van betaling / Date of payment

4 Betaling van voordele
Payment of benefits

Kontakbesonderhede / Contact details

Posadres
Postal address _____

Woonadres
Residential address _____

Telefoonnommer
Telephone number (_____) _____

Bankbesonderhede / Bank details

Naam van bank _____ Tak _____
Name of bank _____ Branch _____

Tipe rekening: Lopend Spaar Transmissie
Type of account: Current Savings Transmission

Rekeningnommer
Account number _____

Belangrik:

Important:

Indien voordele in u bankrekening betaal moet word, voorsien ons asseblief van 'n gekanselleerde tjek of 'n gesertifiseerde inlegstrokie in geval van 'n spaarrekening.
If the benefits are to be paid into your bank account, please provide us with a cancelled cheque or a certified deposit slip in the case of a savings account.

Belastingbesonderhede / Tax particulars

Inkomstebelastingverwysingsnommer
Income tax reference number _____

Inkomstekantoor waar vorige opgawe ingedien is
Income tax office to which last return was rendered _____

5 Algemeen
General

Verstrek asseblief enige ander inligting wat na u mening die eis kan beïnvloed.
Please give any other information which, in your opinion, may influence the claim.

Premiebetaling moet voortgaan totdat 'n eis, indien enige, erken is.
Premium payments must continue until claim, if any, is admitted.

6 Verklaring Declaration

Ek verklaar dat ek die persoon is wat hierbo beskrywe word en dat die antwoorde en die opgawes deur my hierbo verstrek in elke opsig waar en korrek is.

Terwyl ek aanvaar dat ek my reg op privaatheid daardeur inkort, maar om die beoordeling van die risikos en die oorweging van enige eis om voordele makliker te maak, ingevolge 'n polis verband hou met hierdie of enige ander aansoek om versekering deur my, of aangaande my as versekerde, magtig ek Sanlam onherroeplik om:

- Enige inligting wat Sanlam nodig ag van enige persoon te bekom - wat ek hiermee magtig en versoek om die inligting aan Sanlam te gee.
- Daardie inligting en enige inligting in hierdie aansoek of enige verwante polis of ander dokument vervat met ander versekeraars te deel - hetsy regstreeks, hetsy deur 'n databasis wat deur of vir versekeraars as 'n groep bedryf word, te enigertyd (selfs na my dood) en in sodanige gedetailleerde, of verkorte of gekodifiseerde vorm waarop Sanlam of die operateurs van die databasis van tyd tot tyd besluit.

I declare that I am the person described above and that the replies given to the questions and the statements made above are true and correct.

Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks and the consideration of any claim for benefits under a policy related to this or any other proposal for insurance made by me, or in respect of me as insured, I irrevocably authorise Sanlam to:

- Obtain from any person whom I hereby so authorise and request to give any information which Sanlam deems necessary.
- Share with other insurers that information contained in this proposal or in any related policy or other document, either directly or through a data base operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Sanlam or by the operators of such data base.

Handtekening

Signature _____

Getuie

Witness _____

Datum

Date _____ (dd/mm/eejj)

Plek

Place _____

Verslag deur die behandelende spesialis

Belangrik: Hierdie verslag moet deur 'n spesialis opgestel word en nie deur 'n algemene praktisyn nie.

Geagte dokter

Voordat u die ondersoek doen, moet u die identiteit van die versekerde met behulp van 'n fotografiese identiteitsbewys vasstel. Dui asseblief aan op u ondersoekbevindings watter soort identiteitsbewys aangebied is.

Wanneer 'n ongeskiktheidseis evalueer word, moet ons onderskei tussen die twee hoofbeginsels van **funksionele inkorting** en **ongeskiktheid**. Die evaluering van **funksionele inkorting** behels uit 'n praktiese oogpunt dat 'n diagnose gemaak en daarna op mediese grond bepaal word watter funksie die persoon nog kan verrig en watter nie. Aan die ander kant is **ongeskiktheid** 'n regsproses waar die omvang van die persoon se **funksionele inkorting** beoordeel word aan die hand van sy/haar posbeskrywing, die bewoording in die polis en persoonlike faktore soos opleiding, ondervinding, ensovoorts.

Om ons te help om 'n regverdigte besluit te neem, moet ons voorsien word van 'n verslag betreffende **funksionele inkorting** van hierdie persoon. Die besluit oor **ongeskiktheid** sal deur Sanlam Lewensversekering Bpk ("Sanlam Beperk") geneem word.

Voorsien ons asseblief van 'n verslag volgens die riglyne soos uiteengesit in die *Riglyne vir mediese verslag oor funksionele inkorting* hieronder, nadat die persoon ondersoek is.

Die versekerde is verantwoordelik vir die koste verbonde aan hierdie konsultasie en mediese verslag. Indien u dit nodig ag om verdere ondersoeke te doen, sal dit ook vir die versekerde se rekening wees.

Riglyne vir mediese verslag oor funksionele inkorting

Gebruik die volgende asseblief slegs as riglyn om u verslag op te stel.

- Diagnose (*DSM IV vir psigiatriese toestande*)
- Datum van aanvang en verloop van siekte
- Erns: *Aanleidende faktore, sekondêre voordeel*
- Huidige kliniese bevindings. *Beskryf volledig.*
- Behandeling
 - Behandelingsmodaliteite
 - Tipe medikasie en dosering
 - Tydsduur en behandeling
 - Terapeutiese prosedure
 - Rehabilitasie
 - Hospitalisasie
- Reaksie op behandeling
- Komplikasies wat permanent is.
- Spesiale ondersoeke (bv. EKG, X-strale, skanderings)
- Prognose met optimale behandeling
- Invloed op lewenstyl, aktiwiteite van daaglikse lewe en werksaktiwiteite
- Spesiale vereistes
 - Kardiovaskulêr: NYHA klassifikasie, oefeningskapasiteit, inspannings EKG, uitwerpfraksie, ander.
 - Respiratories: dispnee-gradering(ATS), oefeningskapasiteit,(METS of VO2 max.) vitalogram voor en na -inhalasie (3 pogings), borskas X-strale, enkel inasemingdiffusietoets (Dco) in gevalle van interstisiële longsiekte.
 - Ortopedies: X-strale met stres opnames, MRI of CAT skanderings, ander (bv. senuwee-geleidingstoetse).
 - Psigiatry: sosiale funksionering, konsentrasie, psigometriese toetse in gevalle van kognitiewe inkorting.

Report by the treating specialist

Important: This report must be compiled by a specialist and not a general practitioner.

Dear doctor

Before you perform the examination, please determine the insured's identity with the help of a photographic proof of identity. Indicate on the report of your findings - what type of proof of identity was given.

The assessment of a disability claim is based on the two main principals of **impairment** and **disability**. The assessment of **impairment** entails in practical terms, making a diagnosis and then determining on medical grounds which functions the person is still able to perform and which not. On the other hand, **disability** is a legal process assessing the extent of the person's **impairment** judged in conjunction with his/her job description, the policy wording and personal factors such as education, experience, etc.

To assist us in making a justified decision, we have to be provided with a report regarding the **impairment** of this person. The decision regarding the disability will be made by Sanlam Life Insurance Ltd ("Sanlam Life").

Please supply us with a report in accordance with the guidelines set out in the *Guidelines medical report on functional impairment* underneath after you have examined the insured.

The insured is responsible for the costs relating to this consultation and medical report. Should you require additional investigations, these will also be for the account of the insured.

Guidelines medical report on functional impairment

Please use the following only as a guideline to compile your report.

- Diagnosis (DSM IV for psychiatric conditions)
- Date of onset and course of disease
- Severity Perpetual factors, secondary gain
- Current clinical findings. Detailed description
- Treatment
 - Treatment modalities
 - Types of medication and dosage
 - Duration of treatment
 - Therapeutic procedures
 - Rehabilitation
 - Hospitalisation
- Response to treatment
- Complications that are permanent
- Special investigations (e.g. ECG, X-rays, scans)
- Prognosis with optimal treatment
- Influence on lifestyle, activities of daily living and working capability
- Special requirements
 - Cardiovascular: NYHA classification, exercise capacity, stress ECG, ejection fraction, other
 - Respiratory: dyspnea-grading(ATS), exercise capacity, (METS or VO2 max.) vitalogram pre-and post-inhalation (3 attempts), chest X-ray, single-breath diffusion test (Dco) in cases of interstitial lung disease
 - Orthopaedic: X-ray and stress views, MRI or CAT scans, other (eg. nerve conduction tests)
 - Psychiatric: social functioning, concentration, psychometric tests in cases of cognitive impairment