momentum
corporate

Disability claim - employee declaration

Employee/member 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.

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.

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

Gender Male Female

Marital status Married Single Divorced Widowed

Home language

Telephone - work Fax

Telephone - home Cell

Email

Residential address

Postal code

Postal address

Postal code

Income tax office

Income tax number

Do you belong to a medical aid? Yes No

If yes, give details
Name of scheme

Membership no When did you join? D D - M M - Y Y Y Y

When will your membership stop/when do you expect it to stop? D D - M M - Y Y Y Y

3. Details of occupation

Date when you started working for your current employer D D - M M - Y Y Y Y

Date when you started in your current occupation/position D D - M M - Y Y Y Y

Job title

Details of duties. List five key activities and give a brief description of each.

1.

2.

3.

4.

5.

Have you been able to perform part of your job, or another job, since your impairment? Yes No

If you have performed another job, or if your job was changed, please give details of the job that you did, the date that it changed/started, and salary that you were paid.

4. Details of employment history

Apart from your present occupation, please supply a brief employment history, including previous positions held at current and previous employers.

Date started	Date ended	Company	Position held	Type of work	Salary at date of leaving	Reason for leaving

5. Qualifications, training and experience

	Year achieved	**Standard/Qualification**
Highest level of schooling		
Technical qualifications (NTC, diplomas, etc.)		
Academic qualifications (e.g. degrees, etc.)		
Other training (e.g. certificates,in-house training, driver's licences & codes)		

What alternative occupation/s do you consider yourself qualified for?

6. Details of impairment

Date last able to actively perform your normal occupation DD - MM - YYYY

an alternative occupation DD - MM - YYYY

When do you expect to be able to take up any occupation in the future?

On a part-time basis? DD - MM - YYYY On a full-time basis? DD - MM - YYYY

What is your current employment status? Please tick the appropriate box.

Working full-time ☐	Working part-time ☐	On sick leave ☐	On unpaid leave ☐
Laid off or retrenched ☐	Dismissed ☐	Other ☐	

If Other, please specify.

Please complete if your impairment arose from an accident or other violent means.

Date of accident DD - MM - YYYY

What type of accident/incident occurred?

Police station where reported

Police case number

List of diagnoses/symptoms/complaints.	Date first noticed
	DD - MM - YYYY
	DD - MM - YYYY
	DD - MM - YYYY
	DD - MM - YYYY

How does the impairment affect you in doing your normal duties?

Which duties can you no longer do?

Which duties can you still do?

Have you, in the last 5 years, suffered from any serious disease, illness or disablement? Yes ☐ No ☐

If Yes, please provide details.

Details of any hospitalisations within the last 2 years.

Name of hospital	Date of admission	Date of discharge	Reason for admission	Surgery performed (if applicable)

Current treatment. Please list all medication you are on, provide name and dosage.

6. Details of impairment (continued)

Please give the names of all doctors, specialists and hospitals you have consulted in connection with your impairment/disability. Please provide us with the telephone number and email address as we may need this to communicate with your doctor.

Date from				
Date to				
Hospital / Doctor				
Speciality				
Tel no.				
Email address				
Patient Number				

Please give the name, postal address, email address and telephone number of your regular family doctor/general practitioner.

Name

Postal address

Postal code

Email address

Tel No.

Date that you first visited your current general practitioner D D – M M – Y Y Y Y

When was your last consultation? D D – M M – Y Y Y Y

If you have changed general practitioners in the last two years, please give details of all previous attending general practitioner/s.

Dates				
From	To	Doctor’s name	Hospital/Practice name	Tel no

7. Current activity profile

Please indicate your hobbies and interests.

Please indicate how you generally spend your day since you have been suffering from the impairment.

06h00 - 07h00	
07h00 - 08h00	
08h00 - 09h00	
09h00 - 10h00	
10h00 - 11h00	
11h00 - 12h00	
12h00 - 13h00	
13h00 - 14h00	
14h00 - 15h00	
15h00 - 16h00	
16h00 - 17h00	
17h00 - 18h00	
18h00 - 19h00	
19h00 - 20h00	
20h00 - 21h00	
21h00 - 22h00	

8. Psychosocial details

Please complete the questions below by selecting one answer per question. The answer you select should be the one that best describes you.

8.1. Work dynamics

1. How long have you been in your role? Less than 1 year ☐ | 1 - 2 years ☐ | 3 - 4 years ☐ | 5 - 6 years ☐ | 7 years or more ☐
2. How would you describe your relationship with your employer? Excellent ☐ | Very good ☐ | Average ☐ | Poor ☐ | Very poor ☐
3. What was your performance rating for the last 12 months? Excellent ☐ | Very good ☐ | Average ☐ | Poor ☐ | Very poor ☐
4. What is the duration you travel to work every day (one way in minutes)? 0-15 ☐ | 15-30 ☐ | 30-45 ☐ | 45-60 ☐ | More than 1 hour ☐
5. Since you went on disability, has your employer contacted you to show any support? Yes ☐ | No ☐

8.2. Personal assessment

1. When do you see yourself returning to work? 3 months or less ☐ | 4 – 6 months ☐ | 7 – 12 months ☐ | more than 12 months ☐ | Never ☐
2. Do you feel that you have the necessary support to recover? Yes ☐ | Partially ☐ | No ☐
3. Is there anybody assisting or supporting you at home? Yes ☐ | No ☐
4. Are there people at home who are dependent on you (financially or otherwise)? None ☐ | Children ☐ | Spouse ☐ | Children and spouse ☐ | Children /spouse AND elderly parents AND extended family ☐ | Children /spouse AND elderly parents OR extended family ☐ | Only parents OR extended family (no children/spouse) ☐

8.3. Value system

1. Which of the following do you value most in life? Ability to work ☐ | Family and friends ☐ | Financial freedom ☐ | Health ☐
2. Which of the following frustrates you most in life? Work ☐ | Financial freedom ☐ | Ill health ☐ | Relationships ☐ | Uncertainty ☐
3. Do you recharge when socialising, or spending time alone? Socialising ☐ | Spending time alone ☐
4. Do you participate in hobbies in your spare time? Yes ☐ | No ☐
5. What hobbies do you enjoy doing? Gymming/exercising ☐ | Reading or watching TV ☐ | Crafts ☐ | Cooking/baking ☐ | More than 1 of the above ☐ | Other ☐ | Not applicable ☐

8.4. Clinical aspects

1. When did the first symptoms of your disabling condition start? Less than 6 months ago ☐ | Between 6 - 12 months ago ☐ | Between 1 – 2 years ago ☐ | Between 3 – 5 years ago ☐ | More than 5 years ago ☐
2. How have your sleep patterns changed since being diagnosed with your medical condition? I'm sleeping less: struggle to fall asleep and/or wake up frequently ☐ | I'm sleeping more ☐ | My quality of sleep has deteriorated in another way not listed ☐ | No changes ☐
3. On average, how many hours do you sleep per night? Less than 6 ☐ | 6 - 9 hours ☐ | More than 9 ☐
4. Are you consulting in private or public health care? I am not consulting anymore ☐ | Private Health Care ☐ | Public Health Care ☐
5. Do you have a medical scheme that assists you with rehabilitation? No ☐ | Partially ☐ | Yes ☐
6. How severe is your medical condition? Mild ☐ | Moderate ☐ | Severe ☐

9. Income detail

Income prior to your impairment.

Normal salary or wages per month	Bonuses or overtime (monthly average last year)	Commission (monthly average last year)	Other

Current or expected future income.

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

10. Employee banking details

Name of account holder			
Name of bank			
Account number		Branch no.	
Type of account	Current/cheque	Savings	Transmission

11. Declaration & consent to collect and share personal and health information

First name/s	
Surname	
RSA ID	Yes [ ] No [ ] ID / Passport no
Passport country of origin	

Declaration

I ______________________ (full name of member),

declare that all the information given on this claim form is true and correct, and that no material information has been withheld. I understand that any incorrect and/or misrepresentation of information could be used as a reason for the claim not being approved.

Consent to collect and share personal, medical and health information
Momentum Corporate may process all information provided on this form. Information will be processed in accordance with the Protection of Personal Information Act, 2013 and Momentum Corporate's strict policies on protecting the confidentiality of my personal information. Momentum Corporate's full privacy policy can be found on www.momentum.co.za.

I consent and give permission for:

- any health practitioner (e.g. doctor, psychiatrist, etc.), allied health practitioner (e.g. occupational therapist, psychologist etc.), medical institution, medical aid, employer, insurance company, health risk management service provider appointed by my employer/policyholder or any other person or institution that has information about my health, employment related activities and personal information, to provide this information to Momentum Corporate or any third party nominated by Momentum Corporate who requires this information for the purposes of assessing and managing my claim.
- Momentum Corporate to share any medical, occupational and personal information contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, with a health practitioner, allied health practitioner, health risk management service provider appointed by my employer/policyholder, or any third party nominated by Momentum Corporate who may require such information for the purpose of assisting Momentum Corporate in the assessment and management of my claim or for assessing the payment of a benefit under a risk policy where I am the policyholder.
- Momentum Corporate to share any medical, occupational and personal information contained in medical reports or otherwise, which they have obtained in the course of the assessment of my claim, with other insurers for the purpose of assessment of any related claim that I might have against that insurer, and with Astute for statistical purposes and for the management of over insurance and fraud in the insurance industry.
- Momentum Corporate to send correspondence, which may include personal and special personal information, regarding my claim to my employer/policyholder or its appointed intermediary. The purpose of this correspondence is to inform them of the status and outcome of my claim.
- Momentum Corporate to provide my employer/policyholder or its appointed intermediary with regular claims status reports which will contain personal information. Momentum Corporate will not share any health related information in the status reports unless I have given express written consent.
- Momentum Corporate to share all medical and health related information (special personal information) with the following third parties (please select from the list below):
  - [ ] Employer/policyholder (including their representatives) involved with my claim
  - [ ] Financial Advisers and Intermediaries appointed by my employer or myself
  - [ ] Any other person/s appointed by me in writing
  - [ ] All of the above
  - [ ] None of the above

Momentum Corporate will share medical and health related information with third parties at its discretion. I confirm that I will not hold Momentum Corporate, its employees, directors or agents liable in any way and I indemnify and hold Momentum Corporate harmless for the sharing of health related information in line with this consent.

I confirm that I know and understand this consent I am providing to Momentum Corporate and that I am doing so voluntarily.

Click here to read the full consent document. (https://www.momentumpartnershipconnect.co.za/momentum-corporate-popia-member-document/)

***Signature of Member**	D D - M M - 2 0 Y Y **Date**

***If member is unable to sign the consent due to medical incapacity, please contact us so that we can further assist.**

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.