DISABILITY BENEFIT APPLICATION FORM

PART TWO : EMPLOYEE DECLARATION

IMPORTANT: (i) This Form is to be completed by the Employee.
(ii) Full and accurate answers are to be elicited and recorded. This declaration will be used in the assessment of your claim.
(iii) The request to complete this form in no way constitutes an admission of liability by the fund or Insurer.

1. PERSONAL PARTICULARS

Surname:			
First Name:			
Date of Birth	DD / MM / YYYY		
Member's ID Number:			
Employer Name and Division:			
Occupation:			
Company reference number:			
Telephone Number	Home	Work	Mobile
Medical Aid Name		Medical number	
Residential address			
Postal Address			
Date Joined the Company:	/ /	Date Joined the Fund / Scheme:	/ /
Last day actively at work:	/ /	Date of Disability:	/ /

2. DETAILS OF OCCUPATION

What is your current position? (full details of job to be provided in section 5 and 6 of this form)?

Are you still working in this position?	Y	N
Please give details of current activities, duties and functions:		
Are you a fulltime employee?	Y	N
Date appointed to fulltime staff:	/ /	
Salary prior to date of disability:		
Are you still receiving a salary?	Y	N
Current salary amount:		
If you not receiving a salary up to what date were you last paid:		
When do you intend ceasing this salary?		
Date appointed to fulltime staff:		
Have you or do you intend to resume work?	Y	N
If you resume work is it on a full time basis or part time basis?		

If you have returned to work after an illness or incapacity, are you working in the,

Same Job	
Adapted job	
Alternative job	

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Work History			
Apart from your present job, please supply your work history over the past 10 years			
From	To	Company	Position or Responsibilities

3. DETAILS OF EDUCATION AND TRAINING

Please provide details highest level of schooling, post-school education and training (academic, technical, in-service, etc)		
Year	Institution	Qualification

4. DETAILS OF DISABILITY

Describe the illness / that has given rise to this claim			
When did you first experiences symptoms relating to this disability. Please describe these symptoms?			
When did you first consult a medical practitioner in respect of your current Disability?	/ /		
Please Provide details of who the medical practitioner was that you consulted,			
Name of Medical practitioner			
Address			
Telephone number			
Have you suffered from any other form of disablement or been declared disabled from employment before		Y	N
If yes, please provide details,			
Provide details of any other concurrent or past illnesses / injuries which you feel may have contributed to your disability			

Current treatment and medication (list all medication and dosages		
Ailment / Illness	Medication	Dosage

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5. DETAILS OF MEDICAL PRACTITIONERS OR MEDICAL EXAMINATIONS

In this section provide details of all medical practitioners consulted or medical examinations conducted

Family doctor name	
Address	
Telephone number	
Name of doctor who is attending to your disability	
Address	
Telephone number	

Provide details of other medical practitioners including specialists consulted in connection with this disability

Name	Type of Practice / Speciality	Address	Telephone

Have you been referred to any health care professionals e.g. Physiotherapist, Occupational Therapist, Psychologists or other medical specialists etc? Please provide details below:

Name	Date	Type of Practice / Speciality	Treatment	Outcome

Have you had any test, X-rays or special investigations relating to your disability or any other impairment? Please give details

Name	Date	Doctor / Speciality / Hospital	Investigation done	Outcome

Is future surgery planned / required / anticipated?		Y	N

If yes, please provide details

If this claim has arisen from an accident please answer the questions below,

What was the date of the accident?	
How and where did the accident occur?	
Police station where the accident was reported:	
Case number	

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6. WORK PERFORMANCE AND DAILY ACTIVITIES

List the work duties that you are able to perform:

List the work duties that you are not able to perform:

Describe specific difficulties you are experiencing in performing your duties:

Please give full details of your current daily activities:

7. BENEFITS / COMPENSATION FROM OTHER SOURCES

Please provide details of any benefits / compensation from other sources as a result of disability (current or anticipated)

Source	Amount	Date of payment	Period of payment

8. DECLARATION

I _____hereby declare that I am the person insured under the scheme mentioned above. All the particulars given are to the best of my knowledge, true and complete and that I have not omitted or withheld any relevant information. Accepting that I am hereby curtailing my right of privacy, but to facilitate the assessment of risk, and the consideration of any claim for benefits.

I irrevocably authorise and request any doctor or any other person who may be in possession of, hereafter acquire, any information concerning my health, to disclose such information to medworx & Bryte Life, and to share with other insurers that information and any information contained in this declaration or in any related policy or other document, either directly or through a database 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 medworx or Bryte Life or by the operations or such database.

Dated at:	this	Day of	20
Completed by (Full name)		Signature	
Please provide contact details			
Telephone Number		Cell phone Number	
Email address			