

# DISABILITY BENEFIT APPLICATION FORM



## PART ONE : EMPLOYERS DECLARATION

IMPORTANT: (i) This Form is to be completed by the Employer.  
 (ii) Full and accurate answers are to be elicited and recorded.

### 1. GENERAL PARTICULARS OF THE EMPLOYER

Fund Name:			
Company Name:			
Physical Address:			
			Code: <input type="text"/>
Contact Person:			
Fax Number:		Tel Number:	
E-mail address:			
Name of person submitting initial claim advice:			
Designation:			

### 2. GENERAL PARTICULARS OF THE MEMBER/CLAIMANT

Surname:												
First Name:												
Date of Birth	DD / MM / YYYY											
Member's ID Number:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer Name and Division:												
Occupation:												
Company reference number:												
Telephone Number	Home			Work			Mobile					
Date Joined the Company:	/ /						Date Joined the Fund / Scheme:			/ /		
Last day actively at work:	/ /						Date of Disability:			/ /		
Cause of Disability: (if known)												
(Please include a copy of the member's last payslip)												

### 3. DETAILS OF EMPLOYMENT

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

Is the member still working? Y N

If "Yes", please give details of current activities:

Is member a fulltime employee? Y N

Date appointed to fulltime staff: / /

Salary prior to date of disability:

Is the member still receiving a salary? Y N

Current salary amount:

Effective date: / /

When do you intend ceasing this salary? / /

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When do you expect the member to resume work?	Part time:	/ /	Full time:	/ /
If the member has returned to work, please specify in what capacity				
Same Job				
Adapted job				
Alternative job				
<b>4. DETAILS OF DISABILITY</b>				
Please provide details to the best of your ability or knowledge as to the Disability/incapacity of the member				
What do you understand to be wrong with your employee?				
State the date of the first indication of disability	/ /			
State the nature of the first indication of disability				
How does the disability affect the member's ability to perform his / her duties				
Complete the member's sick leave record for the last 2 years				
From	To	Number of working days	Reason	
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			
Only to be completed if the member has recovered / partially recovered / is anticipated to recover				
Date of illness / accident / injury	/ /			
Nature of illness / accident / injury (attach copies of medical certificates, hospital notes or other relevant medical information)				
Nature of the Illness/accident/Injury Date	Name and address of attending doctor or hospital		When did the member have symptoms?	Do you have medical records?
				Y N
				Y N
				Y N
				Y N
				C N
Date member resumed duties following illness / accident injury	/ /			
Total number of days absent from work due to the above-mentioned illness / injury				
If the member has returned to work, please specify in what capacity				
<b>5. MEMBER'S EXPERIENCE AND TRAINING</b>				
Apart from the members present job, please supply a brief job history, including previous positions the member has held within your company				
Date		Position held within Company	Type of work done	
From	To			
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			

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If there has been a reduction in the member's own job responsibilities, please list the members own job responsibilities that he / she is able to perform

Please list any alternative duties within your organisation that the member could perform.

(In accordance with the revised Labour relations Act, 1996, employers are obliged to be proactive in the realignment, reskilling and retraining of employees who are unable to perform their regular functions due to illness / accident / injury.)

Please comment on any steps taken with regard to this particular member.

## 6. DETAILS OF JOB DESCRIPTION

List the essential and regularly performed work tasks with a brief description of each

Tasks performed	Brief description

### Work duties

Type of work Duties	% of time spent performing
Administrative / clerical / professional	
Manual / Handling machinery or equipment	
Commercial work (buying / Selling)	
Supervision or inspection	
Other duties, please specify	

What is the minimum training / education required to perform this job?

School	Y	N	Standard	
Technical	Y	N	Diploma	
Professional	Y	N	Degree	
On the job training	Y	N	Months	
Other:				

### Work environment

Exposure to adverse conditions	Exposed (Yes / No)		If yes, describe.
Extreme Temperatures	Y	N	
Nose	Y	N	
Dust	Y	N	
Fumes	Y	N	
Heights / Depths	Y	N	
Rough terrain	Y	N	
Other Hazards, please specify	Y	N	
	Y	N	
	Y	N	

Specify machinery, equipment, tools and materials being used:

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Physical Demands				
Complete the table below indicating the amount of on-the-job time spent on the following activities each working day				
Activity	Never	Sometimes	often	Always
Standing				
Walking				
Sitting				
Use of both hands				
Reaching above shoulder height				
Reaching below shoulder height				
Climbing and balancing				
Kneeling and crawling				
Bending				
Lifting and carrying				
Pushing and pulling				
Working in cramped conditions				
Hearing essential				
Visual activity essential				
Other, please specify				
Please describe the minimum physical abilities that a healthy individual requires to do this job (e.g. percentages, kilograms, meters, hours, numbers (how much), bags sacks (what))				
Strength	What / Where		How much	
Lift (Kilograms)				
Hold (Kilograms/time)				
Carry (Kilograms/meters)				
Push (Kilograms/meters)				
Pull (Kilograms/meters)				
Hold (Kilograms/time)				
Endurance	What / Where		How much	
Climb (Meters)				
Stoop (Percentage of day)				
Stand (Percentage of day)				
Sit (Percentage of day)				
Walk (Percentage of day)				
Other (Percentage of day)				
Accuracy	What / Where		How much	
Fine precise movement				
Control of tools				
Other				
Summary: In view of the member's current medical condition, please describe the physical effort it takes to do this job (e.g. walking, climbing, drilling or the physical environment, etc.)				

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Mental Demands				
Indicate how much of the member's job requires the following abilities:				
Abilities	Never	Sometimes	Often	Always
Verbal communication				
Written communication				
Calculation / figure work				
Concentration				
Memory				
Following instructions				
Giving Instructions				
Planning				
Problem Solving				
Decision making				
Specialised knowledge				
Other, specify				
Describe any other factors, either at work or outside work, which could be contributing to the employees difficulties in performing his / her duties satisfactorily				
7. ALTERNATIVE EMPLOYMENT OPPORTUNITIES				
List Alternative jobs in the company, together with a brief description, which the employee may be asked to perform in the future				
Alternatives	Brief description			
8. 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	
9. DECLARATION				
I hereby declare that the employee has been informed of the conditions of the Fund / Scheme rules concerning disability benefits.				
I hereby declare that the above statement is true and correct to the best of our knowledge and that no information has been withheld nor has any relevant information regarding the circumstances been omitted.				
Dated at:	this	Day of	20	
Completed by (Full name)		Signature		
Please provide the account details to be used once claim is admitted				
Name of Account holder		Name of Bank		
Name of Branch and code		Account number:		