

Disability Claim Form Classic Range

CLIENT DETAILS

INVESTMENT ACCOUNT NUMBER																					
NAME/S																					
SURNAME																					
IDENTITY/PASSPORT NUMBER																					
DATE OF BIRTH	<table border="1"><tr><td></td><td></td><td>-</td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></tr><tr><td>D</td><td>D</td><td></td><td>M</td><td>M</td><td></td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>			-			-					D	D		M	M		Y	Y	Y	Y
		-			-																
D	D		M	M		Y	Y	Y	Y												
NAME OF MEDICAL SCHEME																					
INCOME TAX NUMBER																					
PERSONAL STATUS	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW/ WIDOWER																				
IF MARRIED, PLEASE STATE OCCUPATION OF SPOUSE																					

CLIENT'S PHYSICAL ADDRESS

COMPLEX / UNIT / HOUSE NUMBER			
COMPLEX NAME / ESTATE			
STREET NUMBER			
STREET NAME / FARM NAME / AREA NAME*			
SUBURB / DISTRICT*			
CITY / TOWN*			
COUNTRY*		CODE*	

*Compulsory fields

CLIENT'S POSTAL ADDRESS

<input type="checkbox"/> SAME AS PHYSICAL ADDRESS	
PO BOX NUMBER	
POST OFFICE NAME	
POSTAL CODE	
PRIVATE BAG NUMBER	
POST OFFICE NAME	
POSTAL CODE	
POSTNET SUITE NUMBER	
PRIVATE BAG NUMBER	
POST OFFICE NAME	



POSTAL CODE

CURRENT OCCUPATION (ALSO APPLICABLE IF SELF-EMPLOYED)

EMPLOYER NAME

CONTACT DETAILS

WHAT WAS YOUR JOB TITLE BEFORE YOUR CURRENT DISABILITY IMPAIRMENT BEGAN?

GIVE AN ACCURATE DESCRIPTION OF THE EXACT DUTIES AND THE NATURE OF YOUR FULL-TIME OCCUPATION (JOB DESCRIPTION)

ADMINISTRATIVE % SUPERVISORY % MANUAL % TRAVEL %

THE LAST DATE YOU WERE ABLE TO UNDERTAKE ANY PART OF THE DUTIES OF YOUR OCCUPATION?

 - -
D D M M Y Y Y Y

WHEN DO YOU EXPECT TO RETURN TO WORK? (IF POSSIBLE)

 - -
D D M M Y Y Y Y

HAVE YOU BEEN OFFERED OR DID YOU ENQUIRE ABOUT ANY ALTERNATIVE OCCUPATION FOR REMUNERATION BY YOUR EMPLOYER?

 YES NO

IF "YES", DESCRIBE DUTIES OF ALTERNATIVE OCCUPATION OFFERED BY YOUR EMPLOYER

HAVE YOU ACCEPTED THE ALTERNATIVE OCCUPATION THAT WAS OFFERED?

 YES NO

FULL-TIME BASIS

 - -
D D M M Y Y Y Y

PART-TIME BASIS

 - -
D D M M Y Y Y Y

WHAT IS YOUR EXPECTED REMUNERATION?

R

IS THE ABOVE MENTIONED YOUR NOMINATED OCCUPATION

 YES NO

IF YES, HOW LONG HAVE YOU BEEN IN THIS OCCUPATION?

 -
M M Y Y Y Y

EMPLOYMENT HISTORY

Occupations held in the past 10 years

EMPLOYER	JOB TITLE	FROM DATE	TO DATE	BRIEF DESCRIPTION OF EMPLOYMENT



SALARY HISTORY

Please provide full details of the member's salary history over the last two years. If the member has worked for the employer for less than two years, please indicate the salary history from the date of appointment.

Date			
Increase amount / percentage			
New salary			
Frequency paid (weekly/monthly/annually)			
Reason for change (annual increase, annual bonus, promotion)			
Estimated amount of additional earnings through overtime, commissions etc.			

INFORMATION RELATING TO YOUR INCOME

STANLIB reserves the rights to call for proof of income and sight of relevant tax forms

WHAT WAS YOUR TAXABLE INCOME FOR THE PAST 12 MONTHS?

R .

COMMISSION EARNED DURING THE PAST 12 MONTHS?

R .

DIRECTOR'S CHARGES FOR THE PAST 12 MONTHS?

R .

HAVE YOU RECEIVED ANY INCOME SINCE DISABLEMENT?

YES

NO

IF "YES", PLEASE STATE INCOME AMOUNT FOR EVERY MONTH SINCE DISABLEMENT

PLEASE PROVIDE DETAILS OF THE SOURCE OF INCOME

HAVE YOU LODGED OR INTEND LODGING A CLAIM FOR PAYMENT OF DISABILITY BENEFITS WITH ANY OTHER PARTY?

YES

NO

NAME OF OTHER PARTY	POLICY NUMBER	DATE OF INCEPTION	ESTIMATED VALUE

ARE YOU CURRENTLY RECEIVING ANY OTHER BENEFITS?

YES

NO

IF YES, PROVIDE MORE DETAILS

INFORMATION RELATING TO IMPAIRMENT

NATURE OF DISABILITY/IMPAIRMENT(S)

INDICATE IF YOUR IMPAIRMENT(S)/DISABILITY IS DUE TO

ACCIDENT/TRAUMA

DISEASE/ILLNESS

DATE OF IMPAIRMENT

- -

D D M M Y Y Y Y



IF THE DISABILITY/IMPAIRMENT IS A RESULT OF AN ACCIDENT, WHEN, WHERE AND HOW DID THE ACCIDENT OCCUR?

Empty text box for accident details.

FULL DETAILS OF INJURIES SUSTAINED

Empty text box for injury details.

NAME OF POLICE STATION

Grid for name of police station.

CASE NUMBER

Grid for case number.

HAVE YOU INSTITUTED A CLAIM FOR BENEFITS AGAINST THE MULTILATERAL MOTOR VEHICLE FUND?

YES checkbox.

NO checkbox.

IF YES, PLEASE PROVIDE A REFERENCE NUMBER UNDER WHICH THE CLAIM WAS LODGED

Empty text box for claim reference number.

If the disability/impairment is due to illness/disease, please provide the following details

DATE THE ILLNESS WAS FIRST DIAGNOSED

DD - MM - YYYY date grid.

Attending doctor/s including specialist/s

NAME

Grid for name of doctor.

STREET

Grid for street address.

SUBURB

Grid for suburb.

CITY/TOWN

Grid for city/town.

COUNTRY

Grid for country.

POSTAL CODE

Grid for postal code.

TELEPHONE NUMBER

Grid for telephone number with dashes.

TELEPHONE NUMBER

NAME

Grid for name of second doctor.

STREET

Grid for street address of second doctor.

SUBURB

Grid for suburb of second doctor.

CITY/TOWN

Grid for city/town of second doctor.

COUNTRY

Grid for country of second doctor.

POSTAL CODE

Grid for postal code of second doctor.

TELEPHONE NUMBER

Grid for telephone number of second doctor with dashes.

TELEPHONE NUMBER

WHAT PRESCRIBED TREATMENT ARE YOU CURRENTLY TAKING/USING?

Empty text box for prescribed treatment.

General practitioner during the last 5 years

NAME

Grid for name of GP.

STREET

Grid for street address of GP.

SUBURB

Grid for suburb of GP.



CITY/TOWN																									
COUNTRY																					POSTAL CODE				
TELEPHONE NUMBER			-							TELEPHONE NUMBER			-												
HAVE YOU BEEN CONFINED TO A	<input type="checkbox"/>	HOUSE	<input type="checkbox"/>	BED	<input type="checkbox"/>	HOSPITAL																			
DURATION	<input type="checkbox"/>	DAYS	<input type="checkbox"/>	MONTHS	<input type="checkbox"/>	YEARS																			

History of all medical consultations/treatments over the last 5 years (treatments for colds and flu may be omitted)

DATE	REASONS	TREATMENT	HOSPITAL/DOCTOR	TELEPHONE

DETAILS OF HOSPITALISATION WITHIN THE LAST 2 YEARS

NAME OF HOSPITAL																								
DATE OF ADMISSION	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
	D	D		M	M		Y	Y	Y	Y														
DATE DISCHARGED	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
	D	D		M	M		Y	Y	Y	Y														

Attending doctor/s including specialist/s

NAME																								
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	D	D		M	M		Y	Y	Y	Y														

BANKING DETAILS FOR PAYMENTS

Payments to third party bank accounts are not allowed. Payments can only be paid into an account in the name of the client.

BANK																								
BRANCH													BRANCH CODE											
ACCOUNT NUMBER																								
ACCOUNT TYPE	<input type="checkbox"/>	CHEQUE	<input type="checkbox"/>	SAVINGS	<input type="checkbox"/>	TRANSMISSION																		
ACCOUNT HOLDER'S ID NUMBER																								
ACCOUNT HOLDER'S NAME																								



SUPPORTING DOCUMENTATION

Please attach the following supporting documentation with the completed claim form:

- Declaration by Employer to consider Disability Claim and to verify that the information is correct
- Medical Reports completed by the Medical Doctor who is currently treating the Client;
- Declaration by the Medical Specialists who have been treating the Client stating that the Client is disabled and unable to find Employment due to the disability;
- Detailed report from the Specialist treating the Client;
- Hospital reports
- A copy of the Accident Report if the Disability was caused by an accident.

DECLARATION *

We are required to collect, process and share your Personal Information (PI). Your PI is collected and processed by our staff, representatives or sub-contractors and we make every effort to protect and secure your PI. You are entitled at any time to request access to the information STANLIB has collected, processed and shared.

I/We agree to provide all documentation and information required in terms of STANLIB's business rules and the Financial Intelligence Centre Act, No. 38 of 2001, and understand that STANLIB is prohibited from processing any transaction on my/our behalf until all such documentation has been provided.

I/We confirm that all information provided herein is true and correct and that I/We have read and understood the contents of this form.

SIGNATURE OF CLIENT / AUTHORISED SIGNATORY *		DATE *	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="text-align: center; font-size: 8px;">D</td><td style="text-align: center; font-size: 8px;">D</td></tr> </table> - <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="text-align: center; font-size: 8px;">M</td><td style="text-align: center; font-size: 8px;">M</td></tr> </table> - <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="text-align: center; font-size: 8px;">Y</td><td style="text-align: center; font-size: 8px;">Y</td><td style="text-align: center; font-size: 8px;">Y</td><td style="text-align: center; font-size: 8px;">Y</td></tr> </table>			D	D			M	M					Y	Y	Y	Y
D	D																		
M	M																		
Y	Y	Y	Y																
		SIGNED AT																	
SIGNATURE OF FINANCIAL ADVISER		DATE	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="text-align: center; font-size: 8px;">D</td><td style="text-align: center; font-size: 8px;">D</td></tr> </table> - <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="text-align: center; font-size: 8px;">M</td><td style="text-align: center; font-size: 8px;">M</td></tr> </table> - <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="text-align: center; font-size: 8px;">Y</td><td style="text-align: center; font-size: 8px;">Y</td><td style="text-align: center; font-size: 8px;">Y</td><td style="text-align: center; font-size: 8px;">Y</td></tr> </table>			D	D			M	M					Y	Y	Y	Y
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		SIGNED AT																	

***Compulsory Section**

