DISABILITY CLAIMANT

TO BE COMPLETED BY THE CLAIMANT

DETAILS OF INSURED

Policy number _____

Surname _____

First name (s) _____

Date of Birth _____

I.D. Number (Please submit proof) _____

Residential address _____

_____

Postal address _____

_____ Postal code _____

Telephone number (_____)_____ Cell No _____

EMPLOYER'S DETAILS

Name of employer _____

Address _____

Telephone number (_____)_____

1. When did you commence employment with the above employer? _____
2. What was the date that you last attended work? _____
3. (a) Were you working full time for the above employer? _____
   (b) if no, please give details : _____
   _____
4. (a) Are you still receiving a salary/income? _____
   (b) If not, up to what date were you paid ? _____
   (c) If you are still receiving a salary, has the payment been reduced? _____
   (d) If yes, please fill in details below:

   Full pay: From _____to_____Amount_____

Reduced pay: From _____to_____Amount_____

(e) Did you receive any other benefits from your employer? If so, please state details _____
_____

DETAILS OF OCCUPATION

1. What was your main occupation immediately before your current disability commenced?
   _____
   _____
2. (a) What were the exact duties involved in your occupation immediately before your disability commenced ? Please attach a copy of your job description _____
   _____
   _____
   _____
   _____
   (b) What percentage of normal working hours was spent solely on the following :
   Professional, administrative and/or clerical duties excluding supervision _____%_____
   Commercial duties i.e. personally buying or selling _____%_____
   Supervision or inspection of other person's work _____%_____
   Handling of machinery and/or equipment _____%_____
   Other duties _____
   Please describe these duties fully _____
   _____
   _____
   _____
3. How long have you followed this occupation? _____
4. Have you changed your occupation (even temporarily)? If so, please gee details
   _____
   _____
   _____
5. Previous occupations (if any) for what periods? _____
   _____
   _____
   _____

DETAILS OF INCOME

1. What salary did you receive over the last 12 months _____ R _____
2. Are you able to substantiate this figure with a tax assessment payslip etc.? Please attach
3. If applicable, how much overtime is included in (1) above _____ R _____
4. If applicable, how much commission is included in (1) above _____ R _____

5. During the last 12 months have you earned income from any other source? If so, please give details _____
   _____
   _____
   _____

DETAILS OF DISABILTY

1. What do you understand to be wrong with you? _____
   _____
   _____
   _____
2. State nature and date of earliest symptoms of this disability _____
   _____
   _____
   _____
3. When did you first consult a medical practitioner in connection with your current disability? _____
   _____
4. Name and address of your usual family doctor _____
   _____
   _____
   _____
   _____
5. Kindly provide names, addresses and telephone numbers of all medical practitioners (including specialists etc.) consulted in connection with this disability _____
   _____
   _____
   _____
   _____
   _____
6. Have you had any tests or X-rays? Please describe(e.g. date/doctor/hospital) _____
   _____
   _____
   _____
   _____
   _____
7. State the name, address and telephone number of the doctor/hospital treating you at present? _____
   _____
   _____
8. What treatment are you receiving or have you had? _____
   _____
   _____
   _____
9. (a) Have you been confined to your home as a result of your disability? _____
   _____

(b) If so, please give details and dates _____
_____
_____
_____
_____
_____

10. Are you at present unable to manage your personal affairs or care for your personal needs? If so, in what respect? _____
_____
_____
_____
_____
_____

11. If you are not confined to bed, describe briefly your daily activities _____
_____
_____
_____
_____

12. Has there been any improvement in your condition? If so, please describe _____
_____
_____
_____
_____

13. (a) Have you previously been admitted to a hospital as a result of your current disability? _____
_____

(b) If so, please give name/s of institution(s), details of date(s) of admission and discharge and diagnosis
_____
_____
_____
_____
_____

14. Have you been treated by any doctors, clinics or institutions for any illness or injury in the five year period prior to the commencement of your current disability? If insufficient space, please use a separate sheet

Date of illness /injury(DDMMYY)	Duration of illness/injury	Nature of illness/injury	Doctor of institution	Tel No.

15. (a) Did your current disability result in you becoming entirely unable to perform the duties involved in your occupation? _____
_____

(b) If no, what part of these duties have you been unable to perform? _____
_____
_____

_____
_____
_____
_____
_____
_____
_____
_____

16. As regards the duties involved in your occupation: _____
    (a) When were you last able to carry out all your duties? _____
    (b) When do you expect to be able to perform some of these duties? _____
    (c) When do you expect to be able to perform all of these duties? _____
17. If this claim arises from an accident, please answer these questions below : _____
    (a) What was the date of the accident ? _____
    (b) How and where did the accident occur ? _____
    _____
    _____
    _____
    (c) If a road accident, please supply address of the police station to which the accident was reported ____
    _____
    _____
    (d) Nature of injuries sustained in the accident _____
    _____
    _____
    _____
    _____
    _____
18. If this claim arises from sickness, please answer this question _____
    (a) Description of the disease (to the best of your knowledge) _____
    _____
    _____
    _____
    (b) When were the symptoms first noticed ? _____
    (c) Have you ever suffered from this disease in the past? _____
    (d) If yes, when? _____
19. (a) Have you received or are you receiving or do you expect to receive any benefit, salary or remuneration whatsoever because of or during your disability? (This includes payments received from any employer, any other insurance company, pension fund, a retirement annuity, any state fund, or from any other source.) _____
    (b) if yes, please give details below

LUMP SUMS		
Source of benefit	**Amount of Lump Sum**	**Date of payment**

REGULAR AMOUNTS			
Source of benefit	**Amount of benefit**	**Date of commencement of payment**	**Date of final payment**

DECLARATION

I confirm to the best of my knowledge and belief that I am solvent and my Estate has not been sequestrated; that the above policy of insurance/assurance is still my bona fide property and has not been alienated by cession or otherwise, except : _____

_____

_____

_____

and hereby authorize any medical practitioner, hospital or any other person to furnish GUARDRISK or its appointed representative, with any information relating to my illness or injury. I do hereby declare and warrant that the answers given by me in this report are in every respect factual, true and correct and that no material information has been withheld nor has relevant information regarding the circumstances been omitted.

Date _____ Signature of Life assured _____