fin HOME LOANS

DISABILITY CLAIM

TO BE COMPLETED BY THE EMPLOYER

DETAILS OF EMPLOYER

Policy number ____

Name of employer ____

Address of employer ____

____ Postal code ___________

Telephone number (__________) ____

EMPLOYEE'S DETAILS OF EMPLOYMENT

Full name of employee ____

Date of Birth and I.D number ____

Date on which employment commenced ____

Date of last day of work ____

Normal monthly salary at time of disability ____

Job title/Occupation ____

DETAILS OF DISABILITY

1. Please provide specific details of all duties performed by the employee. Please attach a copy of his/her job description.
____
____
____
____
____
____

2. What physical positions are adopted by the employee in the performance of his/her duties (e.g. sitting, kneeling, bending, climbing, reaching overhead, lifting etc.)? _____________________________________
____
____
____

3. Describe the difficulties the employee experiences in performing the normal duties of his/her occupation
____
____
____
____
4. What duties is the employee currently able to attend to?
____
____
____
____
____
5. Have any attempts been made to redeploy the employee? If so, please provide details
____
____
____
____
____
____
____
6. Please supply a schedule of all medical attention/sick leave taken by the employee in the past 24 months
____
____
____
____
____
____

DECLARATION

I declare that all the foregoing statements are true and correct.

Name (Print) _____________________________

Position in company ______________________________

Date (DDMMYY) _________________________

Signature _______________________________________

Stamp