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Sanlam Risk Benefits

CPC004E

Claim for Disability for professional sportsmen and women

Please return the completed form to: **Living Benefit Claims**

Postal address	PO Box 1, Sanlamhof 7532	Telephone number	(021) 916-3455
E-mail address	livingbenefits@sanlam.co.za	Fax number	(021) 947-5804

Important

- An accurately completed form is essential in order to avoid delays in the assessment process. A claim can be considered only if all required documents and all the supplementary statements (as indicated below) have been completed in full and are in Sanlam Life's possession.
- It is also important that you should understand the implications of the non-payment /payment of this claim on your financial position. We therefore strongly recommend that you should contact your financial advisor to assist you in this regard, at this stage already.
- This form and all relevant documents can be sent to us by e-mail, fax or per post. If readable copies of documents are provided to us, the original documents are unnecessary.

Please supply the following documents:

- The *Declaration by Employer*- form (union/league)
- If you are self-employed, please provide us with proof of the existence of your business, for example audited financial statements or tax assessments and statements, receipts or affidavits from persons with whom business have been done.
- A copy of your identity document.
- Copies of all medical reports including those by which you were medically boarded.
- A report by the treating specialist (attached).
- SAPD-report/Reports of injury sustained at work if a claim was caused by an accident, as well as the result of the investigation if already finalised.

Important: You can only claim for the sickness conditions as listed in your policy contract.

Particulars of insured life

Plan number(s) _____ _____ _____

_____ _____ _____

Surname _____

Full first names _____

Date of birth ____/____/____ *(dd/mm/ccyy)*

Identity number _____ *(Compulsory)* Land of issue _____

Passport number _____ Expiry date ____/____/____ *(dd/mm/ccyy)*

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Rev ☐ Dr. ☐ Prof. ☐ Adv. ☐ Judge ☐

Gender Male ☐ Female ☐

Postal address _____ Postal code _____

Residential address _____ Postal code _____

Contact details: Telephone (home) (____) _____ Fax (home) (____) _____

Telephone (work) (____) _____ Fax (work) (____) _____

Cell phone _____

E-mail address _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Co-habiting ☐ Widowed ☐

Race White ☐ Asian ☐ Coloured ☐ Black ☐ Unknown ☐ *(For statistical purposes)*

Income office _____

Income tax number _____

Plan number(s) _____

Nature of claim (functional impairment)

- What illness, injury of disorder gave rise to your claim?

  _____

- On which date did you consult a doctor regarding these symptoms? ____/____/____ *(dd/mm/ccyy)*
- State the initials, surname, address and telephone number of this doctor.

  _____

  _____

- If different, please state the initials, surname, address and telephone number of the team doctor.

  _____

  _____

- First consultation date: ____/____/____ *(dd/mm/ccyy)*
- Describe the symptoms which you are experiencing and state the date the symptoms began:

  _____

  _____

- Give a brief description of how the symptoms you mentioned have limited your ability to work:

  _____

  _____

- How do you spend your time? _____
- Describe in what respect you have in any way been impeded in attending to your personal affairs or in carrying out the everyday care of your person (Shower, bath, dress, etc.):

  _____

  _____

  _____

Medical history

- State the initials, surname, address and telephone number of your
  - Team doctor: _____

    Telephone number (____) _____ Fax number (____) _____

    Date of 1st treatment at team doctor: ____/____/____ *(dd/mm/ccyy)*
  - Present family doctor _____

    Telephone number (____) _____ Fax number (____) _____

    Since which date have you been consulting your present family doctor? ____/____/____ *(dd/mm/ccyy)*
  - Previous family doctor _____

    Telephone number (____) _____ Fax number (____) _____
- Provide the following information with regard to all other doctors/specialists you have consulted regarding the condition that caused the claim.

Details for hospitalisation for special investigations or treatments

Name of hospital	Reason for hospitalisation	Patient number	Admission *(dd/mm/ccyy)*	Discharge *(dd/mm/ccyy)*
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

Plan number(s) _____

Medical history *(continue)*

Details of doctors, specialists, Sports Institute and consultations

Name and surname	Type of specialist	Address	Telephone number	First consultation *(dd/mm/ccyy)*
			( )	/ /
			( )	/ /
			( )	/ /
			( )	/ /

Public health sector

Name and surname	Type of specialist	Address	Telephone number	First consultation *(dd/mm/ccyy)*
			( )	/ /
			( )	/ /
			( )	/ /
			( )	/ /

- Medical Aid details:
  - Name of the fund _____
  - Membership number _____

Details of injury

- Date of injury ____/____/____ *(dd/mm/ccyy)*
- Place of injury _____
- Give a brief description of how the injury happened:

_____

_____

_____

- If there was an investigation into the cause of the injury, provide the following findings of the investigation:

_____

_____

- Did you suffer any physical loss? Yes ☐ No ☐

  If "Yes", describe the nature of the loss you suffered

  _____

  If the loss did not happen on the date of the injury, please state the date ____/____/____ *(dd/mm/ccyy)*

Plan number(s) _____

Occupational history

What was the last date on which you were actively able to do your work? ____/____/____ *(dd/mm/ccyy)*
(Not necessarily the date of termination of service.)

Date of termination ____/____/____ *(dd/mm/ccyy)*

Rugby:

Were you contracted with a union affiliated with SARU at the time of injury/illness? Yes ☐ No ☐

Were you contracted with an overseas rugby club affiliated with SARPA at the time of injury/illness? Yes ☐ No ☐

Soccer:

Are you formally contracted as a professional soccer player with:

- A local club in one of the top two soccer leagues of South Africa? Yes ☐ No ☐
- An overseas club in one of the top two soccer leagues of the relevant country? Yes ☐ No ☐
- At time of injury/illness were you playing for a club in any of the top 2 soccer leagues? Yes ☐ No ☐
- If not, please confirm with which club you were playing? _____

If you are doing any work at present, from which you are earning an income, state the type of work and the income earned:

_____

Provide the name, address, telephone and fax numbers of the relevant employer:

_____

Telephone number (____) _____ Fax number (____) _____

If you are not working at present, do you intend to do so in the future? Yes ☐ No ☐

- If "Yes", what type of occupation do you have in mind and from which date? From *(dd/mm/ccyy)*

_____

_____

- If "No", in your opinion, what prevents you from performing full-time employment?

_____

_____

Income particulars

Date of termination ____/____/____ *(dd/mm/ccyy)*

Provide the following information if, owing to or during your injury you are receiving, or are entitled to receive any benefit, salary, pension or remuneration of any kind (this includes money received from any employer, partner, assurance company, pension or retirement annuity fund, any government fund or from any other source – irrespective of whether a claim has been submitted):

Source of benefit	Amount (R)	From *(dd/mm/ccyy)*	To *(dd/mm/ccyy)*
Basic salary per month		/ /	/ /
Average match fees per month		/ /	/ /
Average endorsements per month		/ /	/ /

Average over the last 12 months or period of play if less than 12 months

What was your gross monthly income during the last 12 months before the injury? *(Please indicate any overtime payment separately.)*

Gross R _____ Overtime R _____

Plan number(s) _____

Payments

Please note that the payments must be continued until a claim, if any, has been admitted.

Bank particulars

Provide us with a copy of your bank statement (not older than three months) on a bank letterhead containing the account number and account holder's name.

Please complete **ONE** of the 3 options provided.

1. Details of account holder/plan holder

A. Natural person / legal entity

Title _____

Full names and surname / Registered name of legal entity _____

Previous / Maiden name _____

National identity number _____

Issueing country of identity number _____

Nationality/Citizenship _____

Gender Male ☐ Female ☐ Date of birth _____ *(dd/mm/ccyy)*

Country of residence _____

Country of birth _____

Monthly income R _____ Date of last income _____ *(dd/mm/ccyy)*

Residential Address _____

_____

_____ Postal/Zip code _____

Trade name of legal entity _____

Legal entity type:

Listed company ☐ Unlisted company ☐ Close corporation ☐ Trust ☐ Deceased estate ☐ Partnership ☐ Other legal person ☐ Retirement Fund ☐

Non-growth organisation ☐ Non-profit organisation ☐ Charitable organisation ☐ Foundation ☐ State owned enterprises ☐ Joint ownership ☐

Registration number _____ Country of registration _____

Registered address _____

_____

_____ Postal/Zip code _____

Controlling party/Beneficial owner _____

B. Bank details

Account holder _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Type of account Current ☐ Savings ☐ Transmission ☐ Other *(specify)* _____

I, the undersigned, hereby declare that if the above information is not correct, Sanlam Life cannot be held liable for any loss that may arise from the use of this information.

Signature of account holder _____ Date *(dd/mm/ccyy)* _____

Plan number(s) _____

2. Payment to cessionary

Important
If any plan, in terms of which a claim is admitted, has been ceded to another institution or person, payment will be made directly to the cessionary in question. The next section must be completed by the cessionary if applicable.

A. Natural person / legal entity

Title _____

Full names and surname / Registered name of legal entity _____

Previous / Maiden name _____

National identity number _____

Issueing country of identity number _____

Nationality/Citizenship _____

Gender Male ☐ Female ☐ Date of birth _____ *(dd/mm/ccyy)*

Country of residence _____

Country of birth _____

Monthly income R _____ Date of last income _____ *(dd/mm/ccyy)*

Residential Address _____

_____

_____ Postal/Zip code _____

Trade name of legal entity _____

Legal entity type:

Listed company ☐ Unlisted company ☐ Close corporation ☐ Trust ☐ Deceased estate ☐ Partnership ☐ Other legal person ☐ Retirement Fund ☐

Non-growth organisation ☐ Non-profit organisation ☐ Charitable organisation ☐ Foundation ☐ State owned enterprises ☐ Joint ownership ☐

Registration number _____ Country of registration _____

Registered address _____

_____

_____ Postal/Zip code _____

Controlling party/Beneficial owner _____

B. Bank details

Account holder _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Type of account Current ☐ Savings ☐ Transmission ☐ Other *(specify)* _____

I, the undersigned, hereby declare that if the above information is not correct, Sanlam Life cannot be held liable for any loss that may arise from the use of this information.

Or

Plan number(s) _____

Payment to cessionary *(continued)*

I hereby give permission for the cession to be cancelled.

Name of contact person _____ Contact number: ( ) _____

Signature of cessionary _____ Official stamp of institution _____

Date ____/____/____ *(dd/mm/ccyy)*

3. Proxy and/or payment to a third party

If the plan owner would prefer the claim/payment to be handled/received by another person/institution, please provide us with the details below:

I, _____ *(first names and surname of the plan holder),*

hereby authorise the person indicated below to handle the claim/receive the payment on my behalf and I indemnify Sanlam Life against any and all claims in respect of, and in connection with, the payment by Sanlam of the amount(s) concerned to this third party. *(delete where not applicable)*

Initials and surname of the person that could handle the claim on my behalf: _____

Address _____

_____

_____ Postal/Zip code _____

Initials and surname of the person that could receive the payment on my behalf: _____

A. Natural person / legal entity

Title _____

Full names and surname / Registered name of legal entity _____

Previous / Maiden name _____

National identity number _____

Issueing country of identity number _____

Nationality/Citizenship _____

Gender Male ☐ Female ☐ Date of birth _____ *(dd/mm/ccyy)*

Country of residence _____

Country of birth _____

Monthly income R _____ Date of last income _____ *(dd/mm/ccyy)*

Residential Address _____

_____

_____ Postal/Zip code _____

Trade name of legal entity _____

Legal entity type:

Listed company ☐ Unlisted company ☐ Close corporation ☐ Trust ☐ Deceased estate ☐ Partnership ☐ Other legal person ☐ Retirement Fund ☐

Non-growth organisation ☐ Non-profit organisation ☐ Charitable organisation ☐ Foundation ☐ State owned enterprises ☐ Joint ownership ☐

Registration number _____ Country of registration _____

Plan number(s) _____

Proxy and/or payment to a third party *(continued)*

Registered address _____

_____

_____ Postal/Zip code _____

Controlling party/Beneficial owner _____

Source of funds _____

B. Bank details

Account holder _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Type of account Current ☐ Savings ☐ Transmission ☐ Other *(specify)* _____

I, the undersigned, hereby declare that if the above information is not correct, Sanlam Life cannot be held liable for any loss that may arise from the use of this information.

Signature of plan holder _____ Date *(dd/mm/ccyy)* _____

Declaration

I declare that the particulars contained in this form are correct. I also irrevocably authorise any person or institution, medical practitioner, medical specialist, hospital, nursing institution or medical authority to provide Sanlam Life with any information that may be required regarding my health.

Further, I irrevocably authorise Sanlam Life to share with other insurers or any other stakeholders for the purposes of assessing, investigating, processing or any other reason including prevention of fraudulent claims that information and any information contained in this plan or any related plan or other document, either directly or through a data base 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 Sanlam Life or by the operators of such data base.

Signature of insured/claimant _____

Date ____/____/____ *(dd/mm/ccyy)*

Plan number(s) _____

The Treating Specialist

Important
This report must be completed by a specialist and not a general practitioner

Before you perform the examination, please determine the client's identity with the help of a photographic proof of identity. Indicate on the report of your findings – what type of proof of identity was given.

The above-mentioned insured has required us to consider whether he/she qualifies for a disability claim.

The assessment of a disability claim is based on two main principals of impairment and disability. The assessment of impairment entails in practical terms, making a diagnosis and then determining on medical grounds which functions the person is still able to perform and which not. On the other hand, disability is a legal process assessing the extent of the person's impairment judged in conjunction with his/her job description the contract wording and personal factors such as education, experience, etc.

To assist us in making a justified decision, we have to be provided with a report regarding the impairment of this person. The decision regarding disability will be made by Sanlam Life Insurance Ltd ("Sanlam Life").

Please complete the report in accordance with the guidelines set out in the "Guidelines: Medical report on functional impairment" underneath after you have examined the person.

The insured is responsible for the costs relating to this consultation and medical report.

Guidelines : Medical Report on Functional Impairment

Please use the following only as a guideline to compile your report.

- Diagnosis: (DSM IV for psychiatric conditions)
- Date: Of the onset and course of disease
- Severity: Perpetual factors, secondary gain
- Current clinical findings: Describe in detail
- Treatment:
  - Treatment modalities
  - Duration of treatment
  - Rehabilitation
  - Types of medication and dosage
  - Therapeutic procedures
  - Hospitalisation
- Response to treatment
- Complications that is permanent
- Special investigations: e.g. ECG, X-rays, scans
- Prognosis with optimal treatment
- Influence on lifestyle, activities of daily living and working capability

Special requirements:

Cardiovascular	NYHA-classification, exercise capacity, stress-ECG, ejection fraction, other
Respiratory	Dyspnea-grading (ATS), exercise capacity (METS or VO2 max.), vitalogram pre- and post-inhalation (3 attempts), chest x-ray, single-breath diffusion test (DCO) in cases of interstitial lung disease.
Orthopaedic	X-ray and stress views, MRI or CAT scans, other (e.g. nerve conduction tests)
Psychiatric	Social functioning, concentration, psychometric tests in cases of cognitive impairment.