Liberty Group Limited (registration no. 1957/002788/06) - an Insurer and an Authorised Financial Services Provider (no. 2409)
Liberty Centre, 1 Ameshoff Street, Braamfontein, Johannesburg, 2001
PO Box 10499, Johannesburg, 2000
Contact Centre number: 0860 456 789 / +27 (0)11 558 4871
E-mail address: info@liberty.co.za

DISABILITY CLAIMANT'S STATEMENT

We are required to share, collect and process 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 Liberty has collected, processed and shared.

Please send the completed form to Liberty by:

- **Email:** info@liberty.co.za
- **Post:** PO Box 10499, Johannesburg, 2000

Standard requirements – please attach copies of the following documents

☐ Supporting medical evidence (e.g. x-ray reports).

☐ Copy of Life Assured's ID document or copy of the back and front of ID smart card.

Within this form, please note the following:

- "Employer declaration" (to be completed by Life Assured's employer).

Liberty reserves the right to call for additional requirements where necessary.
FAILURE TO RECEIVE ALL THE REQUIREMENTS WILL DELAY THE CLAIM PROCESS.

Section 1 - Contact person for the claim

Title _____ First names _____

Surname _____

Contact numbers: Work _____ Cell _____ Fax _____

Email address _____

Preferred method of communication: ☐ Email ☐ Cellphone ☐ Work phone

NOTE: The claims department will send correspondence and copies only where this information has been supplied. In all other circumstances, correspondence will be directed to the Policyholder/Life Assured.

Section 2 - Policyholder's details

Title _____ Full first names _____ Gender ☐ M ☐ F

Surname/Fund/Company/Trust Name/CC _____ Maiden name _____

ID/Passport/Company registration number _____ Company registration date _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

If company: Country of incorporation _____ Trading name _____

Date of birth _____ Place of birth _____ Country of birth _____

Country of residence _____ South African resident? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Engaged ☐ Married Date of marriage _____

☐ Widowed ☐ Separated ☐ Divorced Date of divorce _____

Email address 1 _____

Email address 2 _____

Contact no's: Home _____ Work _____ Cell _____ Fax _____

Residential address _____ Postal code _____

Postal address _____ Postal code _____

Nominated occupation _____ Industry of occupation _____

Employer name _____

SA Income tax reference number _____ Tax office _____

Section 3 - Life Assured's details (*If the Life Assured and Policyholder is the same person, please only complete Section 3.2 and 3.3.)*

Title _____ Full first names _____ Gender ☐ M ☐ F

Surname _____ Maiden name _____

Marital status: ☐ Single ☐ Engaged ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

ID/Passport number _____ Date of birth _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

Country of residence _____ Relationship to Policyholder _____

SA Income tax reference number _____

Policy number/s

Please note that in the event of any modification or variation of this standard form Liberty will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

3.1 Contact details

Contact no's: Home _____ Work _____ Cell _____ Fax _____

Email address _____

Residential address _____

_____ Postal code _____

Postal address _____ Postal code _____

3.2 Medical aid details

Medical aid name _____

Medical aid number _____

Date joined _____

Is the Life Assured the main member? ☐ Yes ☐ No If "No", please provide the main member's details:

Title _____ First names _____

Surname _____

ID Number _____

3.3 Other information

3.3.1 What is your highest academic, professional or trade qualification? _____

3.3.2 Have you ever been declared insolvent or are any sequestration hearing proceedings, pending or contemplated? ☐ Yes ☐ No

3.3.3 Do you consume any alcohol? ☐ Yes ☐ No

If "Yes", how much alcohol do you consume per week?

Spirit in tots _____ Amount per week _____

Beer, cider in can/bottle _____ Amount per week _____

Wine in glasses _____ Amount per week _____

Note: 1 bottle of spirits = 21 tots, 1 bottle of wine = 6 glasses

3.3.4 Have you ever received advice to reduce or discontinue alcohol consumption, or have you ever been charged with drunken driving? ☐ Yes ☐ No

If "Yes", please provide full details:

_____

_____

3.3.5 Do you currently practice any avocation/s e.g. scuba diving, flying, etc.? ☐ Yes ☐ No

If "Yes", please provide full details:

_____

_____

3.3.6 Please provide the average number of hours that you were working per week, for the three months prior to the date of the claim event:

_____

3.3.7 Were you partially or fully retired at the date of the claim event? ☐ Yes ☐No

If "Yes", please provide full details of when you partially or fully retired and the reasons for your retirement:

_____

Section 4 - Medical information relating to your claim

4.1 What is the medical reason for the claim being submitted?

_____

_____

4.2 Please provide the date of diagnosis or date that the event took place: _____

4.3 Is the medical condition claimed for due to: ☐ Disease ☐ Accident

4.4 If the medical condition resulted from an accident, please provide full details of the accident below. Please also include the police station at which the accident was reported, the case number and attach a copy of the police report to this claim form.

_____

_____

4.5 Please provide the names, addresses and phone numbers of all doctors that you have consulted during the last 5 years (compulsory):

Doctor's name	Contact number	Address	Date of consultation	Reason for consultation

4.6 Please provide details of the doctors from the clinics or hospitals where you were consulting:

Doctor's name	Contact number	Address	Date of consultation	Reason for consultation

4.7 What form of treatment (or medication) are you currently undergoing (or taking)? Please list details below:

Section 5 – Details of current occupation (also applicable to self employed)

5.1 Name and address of last or present employer:

Name

Address Postal code

5.2 Date employed: From To

5.3 What was your full time occupation immediately before your current disability began?

5.4 Please provide a breakdown of your duties:

Administrative %	Supervisory %	Manual %	Travel %

5.5 Please provide an accurate description of the exact nature and duties of your full time occupation (job description):

5.6 Is there any hazard associated with your occupation (e.g. mining, asbestos, handling of explosives, working at heights etc.)? ☐ Yes ☐ No

If "Yes", please provide details:

5.7 Do you or did you travel beyond the borders of the Republic of South Africa in the course of your duties? ☐ Yes ☐ No

If "Yes", please provide the countries that you travel to and the nature of your duties in those countries:

5.8 What date did you stop working?

5.9 When do you expect to return to work?

5.10 Provide details of your current avocations:

5.11 Have you been offered or have you enquired on any alternate occupation for remuneration by your employer? ☐ Yes ☐ No

If "Yes," please provide duties of alternate occupation offered:

5.12 Have you accepted the alternate occupation offered? ☐ Yes ☐ No

5.13 If "Yes," when do you expect to follow this alternate occupation?

☐ On a full time basis ☐ On a part time basis

5.14 Please list all occupations held in the past 10 years (including current occupation):

Employer	Nature of occupation	Date from	Date to

Section 6 – Information relating to your income (Liberty reserves the right to call for financial evidence in order to assess the claim.)

6.1 What was your taxable income for the past 12 months? R

6.2 What was your commission earned during the past 24 months? R

6.3 Please provide director fees over the past 24 months R

6.4 Have you received any income or any other benefits since disablement? ☐ Yes ☐ No

If "Yes," please provide income amount for every month since disablement:

Source of income since disablement	Income amount	Date
	R	
	R	
	R	
	R	

6.5 Have you claimed or do you intend claiming for payment of disability, dread disease, impairment or any similar benefits with any other insurance company? ☐ Yes ☐ No

If "Yes," please provide details:

Name of insurance company	Policy number	Date of inception	Estimated value
			R
			R
			R
			R

Section 7 – Banking details (excluding credit card)

For your protection payment will only be effected by Electronic Fund Transfer, this will also ensure faster payment. Payment may only be made to the Policyholder. Payment can be made to the bank account which is currently paying the premiums subject to the approval of the Policyholder. **Should bank details differ to the account details on record, please provide proof of account i.e. a copy of a cancelled cheque OR copy of current bank statement on a bank letterhead OR a copy of a printout from the bank with a bank stamp.**

Payment must be made into the account of the: ☐ Policyholder ☐ Cessionary (Further instructions must be obtained from cessionary) ☐ Premium payer (if not the same as the Policyholder, permission should be obtained from the Policyholder)

Bank name _____ Account number _____

Branch code _____ Branch name _____

Full first names of account holder _____

Surname/Company name _____

ID/Passport/Company registration number _____ Date of birth/Company registration date _____

If passport: Country of issue _____ Date of issue _____ Date of expiry _____

If company: Country of incorporation _____

Country of residence _____ Relationship to Policyholder _____

Account type: ☐ Cheque ☐ Savings ☐ Transmission

Account holder relationship: ☐ Own ☐ Joint

It is most important to give the correct account number, name and spelling of the account to be credited. Liberty will not bear any responsibility for delays or other damage suffered due to incorrect details being provided.

Section 7 – Declaration

I, _____ (full name and surname), _____ ID number, hereby warrant and declare that the foregoing answers and statements are true to the best of my knowledge and belief, and that I have withheld no material fact(s) from Liberty. I further declare that the condition giving rise to this claim, was not due in any way to self inflicted injury or use of alcohol or drugs of any kind, and that I am not insolvent.

I agree that the written statements and affidavits of all the doctors who attended or treated the Life Assured and all other papers submitted in support of this claim, shall constitute and are hereby made a part of this claim, and further agree that the supply of this form, or any other forms supplemental hereto by Liberty, shall not constitute any admission by it that there is any assurance in force on the life in question or a waiver of any of its rights or defences in law.

I acknowledge and agree that any benefits payable in respect of this claim shall be forfeited if I, or anyone acting on my behalf or with my knowledge or consent, have knowingly withheld any material fact(s) or submitted any false information in respect of this claim. I further agree that upon payment of the benefits hereby claimed, Liberty shall be discharged from all liability in respect of such benefit.

I hereby authorise any medical practitioners, hospitals, clinics, medical aid schemes, pathology, pharmacies, SARS, any other financial institutions or any other source to furnish to Liberty, or its representative any details relating to any illness or injury to the Life Assured or such other information as may be necessary to consider this claim. I know and understand the confidential nature of medical information. By appending my signatures at the end of this declaration, I am agreeing that I have given permission to Liberty to obtain medical information and evidence from and/or through third parties without it being seen as a breach of my right of privacy and confidentiality. I further agree that any authorised medical personnel or practitioner may release confidential information to Liberty or other person acting on their behalf and in such manner or method as Liberty may direct.

I indemnify Liberty and its directors, agents and employees against any claim of whatever nature which may be made against them as a result of or arising out of the furnishing of such information. Where the conditions of the policy so allow, I irrevocably authorise Liberty to deduct any expenses incurred by it in respect of this claim and for which I am liable from the benefits payable under the policy.

In the event that a claimant is both the Life Assured and the Policyholder of the policy and is incapable of managing his/her own affairs, an appointment of a curator bonis will be required in order for Liberty to further assess the claim.

Signed at _____ on _____

_____ _____

Signature of Policyholder Name of Policyholder

_____ _____

Signature of Life Assured Name of Life Assured

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EMPLOYER'S DECLARATION

Note: If self employed, this form must be completed by an accredited auditor/bookkeeper or accountant. **Please note that this form must not be completed by the claimant.**

Section 1 - Employee's details

Title _____ First names _____

Surname _____

ID Number _____

Position in company _____

Medical aid details

Medical aid name _____

Medical aid number _____

Date joined _____

Is the Life Assured the main member? ☐ Yes ☐ No If "No", please provide the main member's details:

Title _____ First names _____

Surname _____

ID Number _____

Section 2 - Employer's details

Company name _____ Company registration number _____

Contact number _____ Fax number _____

Email address _____

Physical address _____ Postal code _____

Section 3 - Occupation details

3.1 What was his/her full time occupation immediately before his/her disability? _____

3.2 Commencement date of occupation: _____

3.3 Please provide a completed and accurate description of the exact duties and nature of his/her full time occupation or enclose a copy of his/her job description:

3.4 Please provide a breakdown of duties:

Administrative %	Supervisory %	Manual %	Travel %

3.5 When was he/she last able to perform part of the duties of his/her full time occupation? _____

3.6 Has he/she been medically boarded? ☐ Yes ☐ No

If "Yes", provide official boarding date: _____

3.7 Were his/her services terminated? ☐ Yes ☐ No

If "Yes", provide date the services were terminated: _____

Reasons for termination: _____

3.8 Was he/she paid for the period that they were booked off? ☐ Yes ☐ No

If "Yes", until when was he/she paid and how much? _____ R _____

3.9 Until what date is renumeration expected to be paid? _____

3.10 Anticipated date that he/she will return to work _____

3.11 Is he/she still engaged in any part of his/her occupation? ☐ Yes ☐ No

If "Yes", please provide details:

3.12 Are you aware if he/she is engaged in any occupation (permanent or part time) after his/her disablement? ☐ Yes ☐ No

If "Yes", please provide details and dates:

Please note that in the event of any modification or variation of this standard form Liberty will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

Section 4 - Alternative duties

4.1 Has any consideration been given to the extent to which the employee's work circumstances or duties might be adapted to accommodate the employee's disability needs? If "No", please provide reasons: ☐ Yes ☐ No

If "Yes", in what capacity?

4.2 In the event of being self employed, please state if the business is to continue? ☐ Yes ☐ No

If "Yes", please specify the amount still being paid to the Life Assured during disability, frequency and the nature of the income (e.g. director fees, drawings etc.)

Amount	Frequency	Nature of income
R		
R		

Section 5 - Details of functional incident/illness

5.1 What was the cause of him/her not being able to work?

5.2 If he/she was injured on duty, please provide us with a short description of the circumstances of the incident/accident:

5.3 Please supply brief history of sick leave, for 2 years prior to disability, for any absence exeeding 2 days:

Date	Details of illness or injury	Number of working days absent	Doctors consulted

Section 6 - Income details

6.1 Please provide remuneration for the past 12 months? R

6.2 Has he/she suffered any loss of income since the illness/injury? ☐ Yes ☐ No

If "Yes", was income stopped or reduced? ☐ Stopped ☐ Reduced

If "Reduced", to how much? R

6.3 Amount still being paid: R

6.4 Commission earner

6.4.1 Taxable salary for the past 12 months R

6.4.2 Commission earned for the past 12 months R

6.4.3 If earning a hourly rate please advise the rate earned per hour for the past 12 months R

6.5 Source of income

6.5.1 Is he/she entitled to a benefit from any other source as a result of the incapacity (e.g. other insurance policies)? ☐ Yes ☐ No

6.5.2 If "Yes", please provide full details:

Section 7 - Declaration

I, hereby declare that I am the person designated and authorised by the above-mentioned company to complete and attest to this form and further confirm that all particulars provided hereto are to the best of my belief and knowledge both true and correct. I confirm that no material information, which is relevant to the assessment of this claim has been withheld, concealed or misstated. (In the event of this form being completed by an Auditor or an Accountant details of their practice numbers must be provided.)

Signed at on

Company stamp

Signature of designated person

Designation