Liberty Group Limited – an Authorised Financial Services Provider
Liberty Centre, 1 Ameshoff Street, Braamfontein, Johannesburg, 2001
PO Box 10499, Johannesburg, 2000
Contact Centre number: 0860 456 789 / +27 (0)11 408 4871
E-mail address: opsclaims@liberty.co.za
Fax No.: (011) 408 2005

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:** opsclaims@liberty.co.za
- **Fax:** (011) 408 2005
- **Post:** PO Box 10499, Johannesburg, 2000

Standard requirements – please attach copies of the following documents

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

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

☐ If assured is claiming under Overhead Expenses Benefit (OEB) or an Income Protection policy we require the last audited account of the business as an additional requirement.

Within this form, please complete the following:

- "Medical Certificate for Disability" (to be completed by doctor/specialist).
- "Employer declaration" (to be completed by life assured's employer).
- "Member information" (SARS requirements).

Overhead expenses claim (in addition to the above)

- The "Overhead Expenses Protector Questionnaire".

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

Surname

First name Initials

Telephone numbers: Work Cell Fax

Email address

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 - Personal details of the life assured

Policy number/s

Surname

First name Initials

Date of birth / /

ID number

Tax reference number

Residential address

Postal code

Postal address

Postal code

2.1 Contact details

Telephone numbers: Work Cell Fax

Home

Email address

2.2 Medical aid details

Medical aid name

Medical aid number

Date joined / /

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.**

CL90111

2.3 Other information

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

2.3.2 Have you or the policyholder/life assured ever been declared insolvent or are any sequestration hearing proceedings, pending or contemplated? ☐ Yes ☐ No

2.3.3 Are you a smoker? ☐ Yes ☐ No

2.3.4 Have you ever been advised to stop smoking? ☐ Yes ☐ No

2.3.5 Do you consume alcohol? ☐ Yes ☐ No

2.3.6 Have you ever been advised to stop consuming alcohol? ☐ Yes ☐ No

2.3.7 Have you ever taken recreational drugs? ☐ Yes ☐ No

Section 3 - Medical information relating to your claim

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

3.2 Please provide the date of diagnosis or date that the event took place.

3.3 Is the medical condition claimed for due to:

☐ Disease ☐ Accident

3.4 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.

3.5 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

3.6 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

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

Section 4 – Details of current occupation (also applicable to self employed)

4.1 Name and address of last or present employer:

Name _____

Address _____

_____ Postal code _____

4.2 Length of service with employer: _____

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

4.4 Please provide a breakdown of your duties:

Administrative %	Supervisory %	Manual %	Travel %

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

4.6 How long have you been following this occupation? _____

4.7 What date did you stop working ?

4.8 When do you expect to return to work?

4.9 Provide details of your current avocations:

4.10 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:

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

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

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

4.13 Please list all occupations held in the past 10 years:

Employer	Nature of occupation	Date from	Date to

Section 5 – Information relating to your income (Liberty reserves the right to call for financial evidence in order to assess the claim.)

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

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

5.3 Please provide director fees over the past 24 months R

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

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

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

5.5 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
			R
			R

Section 6 – 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.**

Account holder's name

Bank name

Account number

Branch name Branch code

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 Signature of life assured

Liberty Group Limited – an Authorised Financial Services Provider
Liberty Centre, 1 Ameshoff Street, Braamfontein, Johannesburg, 2001
PO Box 10499, Johannesburg, 2000
Contact Centre number: 0860 456 789 / +27 (0)11 408 4871
E-mail address: opsclaims@liberty.co.za
Fax No.: (011) 408 2005

MEDICAL CERTIFICATE FOR DISABILITY
(To be completed by the doctor)

We are required to share, collect and process Personal Information (PI). PI is collected and processed by our staff, representatives or sub-contractors and we make every effort to protect and secure this PI.

Section 1 - Doctor's details

Full name

Surname

Postal address

Postal code

Contact numbers: Work Cell Fax

Email address

Practice number

Qualifications

Dear Doctor

We would appreciate your co-operation in providing the information requested in this form.

Insurance disability has two components i.e. functional impairment and disability. The assessment of functional impairment rests with various medical experts and is aimed at establishing the degree of impairment of normal functions due to medical, psychiatric or traumatic causes after reasonable treatment. It also involves the duration of the impairment, whether it is of a permanent or temporary nature, and if temporary the likely duration and prognosis.

The decision regarding disability is a contractual decision taken by the insurance company and is based on details of the claimant, the occupation for which the claimant is insured, the terms and conditions on which the risk was accepted and the policy issued and the medical impairment of the life assured. The information requested, is therefore required to assist us in reaching this decision as quickly as possible.

An extract from the claimant statement that was signed by the life assured states:
"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."

The fee payable for this report is in accordance with Liberty's medical tariffs.

Your assistance will be greatly appreciated and your report will be treated in the strictest of confidence.

Warm regards

Liberty
Claims Management

Confidentiality notice:
This information is intended for the addressee only and may contain confidential and privileged information. If you are not the addressee, the employee or agent thereof you must not take any action based on the information enclosed. If this facsimile is received in error please notify the sender immediately to arrange return at our expense.
Note: Please ensure that this report is submitted to the Claims Department only and not to any other party.

Section 2 - Claimant details

Policy number/s

Surname

First name Initials

ID number

Date of birth / /

Occupation, including discription of duties

Highest qualification

Medical aid's details

Main member

Medical aid name

Medical aid number

Section 3 - Medical history

3.1 Please provide diagnosis

3.2 Date of onset of symptoms

3.3 Date first seen by you

3.4 Date of diagnosis

3.5 Date stopped worked

3.6 Reason for stopping work

3.7 Expected date of return to work

3.8 Name of referring doctor

Contact details: Work Fax

3.9 Have you seen the claimant for any other conditions? ☐ Yes ☐ No

If "Yes", please provide details: ☐ Yes ☐ No

Date of consultation	Reasons for consultation	Treatment prescribed	Duration of complaint

3.10 Please provide the details of any other practitioners, specialists or hospitals to whom the claimant has been referred. Please include copies of all available specialists' reports.

Clinic/Hospital/Specialist	Reason for referral	Contact details

3.11 Symptoms of current condition

3.12 Dates of any diagnoses of any other conditions

3.13 Clinical details indicating severity and permanence of current condition

3.14 Relevant test (e.g. lung function results, blood results, x-ray reports or scan reports, etc.)

3.15 Treatment and response

3.16 Other comments

3.17 Othe major compaint(s)

Section 4 - Results of most recent medical examination

4.1 Date of last examination _____

4.2 Please provide full clinical details as at that examination, including height, weight, blood pressure readings etc. Please include details of any limitations evident at that examination (e.g. joint limitations, visual acuities).

4.3 Does the claimant use tobacco in any form? If 'Yes', please provide details.: ☐ Yes ☐ No

4.4 Is the current medical impairement due to:

4.4.1 Previous illness or injury? ☐ Yes ☐ No

4.4.2 The intentional consumption of alcohol, narcotics or any toxic substance? ☐ Yes ☐ No

4.4.3 Attempted suicide or any self inficted unjury? ☐ Yes ☐ No

4.4.4 Taking of drugs other than under the directions of a registered medical practitioner? ☐ Yes ☐ No

Section 5 - Prognosis

5.1 What are chances of recovery? ☐ Good ☐ Fair ☐ Poor ☐ Nil ☐ Too early to establish

5.2 Are any residual problems likely? If "Yes", please provide details: ☐ Yes ☐ No

5.3 At what time will you be able to establish that residual problems are permanent? _____

5.4 If period off work is to be longer than usually expected for recovery for this condition, please provide specific reasons:

5.5 Is this form completed after an examination or from records? _____

Date of records _____

5.6 Is the claimant able to handle his/her own financial affairs? ☐ Yes ☐ No

5.7 If "No", please provide reason:

Section 6 – Functional abilities

6.1 Please tick the appropriate blocks by indicating the degree and severity level of each Activity of Daily Living (ADL):

Activity	Current limications				Expected future ability		
	No limitation	Mild limitation	Modeate limitation	Impossible	Improve	Remain constant	Deteriotate
Shopping: lifting or carrying groceries	☐	☐	☐	☐	☐	☐	☐
Grasp	☐	☐	☐	☐	☐	☐	☐
Pincer grip	☐	☐	☐	☐	☐	☐	☐
Use of fine motor co-ordination	☐	☐	☐	☐	☐	☐	☐
Holding strengh	☐	☐	☐	☐	☐	☐	☐
Grip strength	☐	☐	☐	☐	☐	☐	☐
Assisted walking	☐	☐	☐	☐	☐	☐	☐
Walking (non-strenuous) over level ground	☐	☐	☐	☐	☐	☐	☐
Walking (strenuous) over uneven ground	☐	☐	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐	☐	☐
Squatting	☐	☐	☐	☐	☐	☐	☐
Stooping	☐	☐	☐	☐	☐	☐	☐
Rise to standing position unaided	☐	☐	☐	☐	☐	☐	☐
Bladder status	☐	☐	☐	☐	☐	☐	☐
Bowel status	☐	☐	☐	☐	☐	☐	☐
Visual fields	☐	☐	☐	☐	☐	☐	☐
Visual acuity – with glasses	☐	☐	☐	☐	☐	☐	☐

Activity	Current limications				Expected future ability		
	No limitation	Mild limitation	Modeate limitation	Impossible	Improve	Remain constant	Deteriotate
Light manual labour	☐	☐	☐	☐	☐	☐	☐
Operating light machinery	☐	☐	☐	☐	☐	☐	☐
Operating heavy machinery	☐	☐	☐	☐	☐	☐	☐
Driving a light motor vehicle	☐	☐	☐	☐	☐	☐	☐
Driving a heavy motor vehicle	☐	☐	☐	☐	☐	☐	☐
Work in cramped conditions	☐	☐	☐	☐	☐	☐	☐
Work in dusty enviroment	☐	☐	☐	☐	☐	☐	☐
Work in a fume enviroment	☐	☐	☐	☐	☐	☐	☐
Higher cognitive functioning	☐	☐	☐	☐	☐	☐	☐
Short term memory	☐	☐	☐	☐	☐	☐	☐
Long term memory	☐	☐	☐	☐	☐	☐	☐
Attention	☐	☐	☐	☐	☐	☐	☐
Language function	☐	☐	☐	☐	☐	☐	☐
Mental behaviour ie. concentration, moods etc.	☐	☐	☐	☐	☐	☐	☐
Interaction with others	☐	☐	☐	☐	☐	☐	☐
Seated/sedentary tasks	☐	☐	☐	☐	☐	☐	☐
Participation in sports	☐	☐	☐	☐	☐	☐	☐
Participation in hobbies	☐	☐	☐	☐	☐	☐	☐

6.2 General comments, which may clarify the responses in the table. If improvement is expected, please indicate the time period in which that improvement is anticipated

Section 7 - Treatment and rehabilitation

7.1 Current medication regime. Please specify all medications and dosages:

7.2 Other treatment the claimant has received or is currently receiving (e.g. physiotherapy, occupational therapy, psychotherapy, etc.):

7.3 Planned future treatment, including surgery:

7.4 Your recommendations regarding rehabilitation (if applicable):

Please attach copies of any correspondence received from any practitioners, specialists or hospitals in respect of the claimant.

Section 8 – Declaration

I, _____ a duly registered doctor/specialist, hereby certify that the information is an accurate reflection of this patient's medical history and is true, correct and complete.

Signed at _____ on _____

Stamp

_____
Signature of doctor/specialist

Please attach a copy of invoice for payment.

Liberty Group Limited – an Authorised Financial Services Provider
Liberty Centre, 1 Ameshoff Street, Braamfontein, Johannesburg, 2001
PO Box 10499, Johannesburg, 2000
Contact Centre number: 0860 456 789 / +27 (0)11 408 4871
Email address: opsclaims@liberty.co.za
Fax No.: (011) 408 2005

MEMBER INFORMATION FORM (SARS REQUIREMENTS)

The South African Revenue Services (SARS) now requires additional information to be included on the tax certificate. In order to avoid delays in processing the request, or penalties imposed by SARS, please complete the following information in full. Please note all fields required below are mandatory.

Section 1 - Member's details

Policy number/s

Surname

First name Initials

ID/Passport number/ Other identification Country of issue

Date of birth / /

Last residential address

Postal code

Income tax number *(compulsory for tax purposes)*

Contact details

Telephone numbers: Work Cell Fax

Email address

Section 2 - Member's last postal address details

Is this the same as the residential address? If "No", provide last postal address: ☐ Yes ☐ No

Postal address

Postal code

Section 3 - Member's last business address

Is this the same as the residential address? If "No", provide last business address: ☐ Yes ☐ No

Business address

Postal code

Section 4 - Member's bank account details (excluding credit card)

Account holder's name

Bank name

Account number

Branch name Branch code

Account type: ☐ Cheque ☐ Savings ☐ Transmission

Account holder relationship: ☐ Own ☐ Joint

Signed at on

Signature of claimant

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.**

CL90911

Liberty Group Limited – an Authorised Financial Services Provider
Liberty Centre, 1 Ameshoff Street, Braamfontein, Johannesburg, 2001
PO Box 10499, Johannesburg, 2000
Contact Centre number: 0860 456 789 / +27 (0)11 408 4871
Email address: opsclaims@liberty.co.za
Fax No.: (011) 408 2005

EMPLOYER'S DECLARATION

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

Section 1 - Employee's details

Policy number/s
Surname
First name Initials
ID Number
Tax reference number
Medical aid name
Medical aid number
Position in company

Section 2 - Employer's details

Full name
Company name
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 give 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 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 or were his/her services terminated?

Official boarding date/date services terminated

Reasons for termination

3.7 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

3.8 Until what date is renumeration expected to be paid?

3.9 Anticipated date that the he/she will return to work

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

If "Yes", please provide details:

3.11 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.**

CL91011

Section 4 - Information required 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 - Information on income

6.1 What are the details of remuneration for 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? If reduced, to how much? R

6.3 Amount still being paid R

6.4 Commission earner

6.4.1 Please state his/her taxable salary for the past 12 months R

6.4.2 Please state his/her 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

CL91111