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

INCOME PROTECTOR CLAIM FORM

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

- ☐ Proof of income, if not submitted at application stage (i.e. salary slip, income and expenses report for business owners, ITA34, commission statements).
- ☐ Supporting medical evidence (e.g. x-ray reports).
- ☐ Personal Medical Attendance (PMA) report will be requested by Liberty directly from the doctor.

Within this form, please complete the following:

- "Medical Certificate for Condition" (to be completed by treating 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", as well as an audited list of expenses.

Liberty and the trustees of the fund reserve 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: Liberty will correspond with the contact person stated above, where this information is not provided, correspondence will be directed to the Financial Adviser on our records.

Section 2 - Policyholder's details

Surname

First name Initials

Telephone numbers: Work ______ Cell ______ Fax ______

Email address

Section 3 - Type of Income Protector claim submitted

Where a claim qualifies for a claim payment under more than one of the claim definitions of the benefit, the claims definition that will result in the highest claim amount will be assessed.

Absolute Income Protector

☐ Guaranteed payment period definition ☐ Occupational disability definition ☐ Impairment definition

☐ Overhead Expenses Protector

Extended Absolute Income Protector

☐ Occupational disability definition ☐ Impairment definition

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 - 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

4.1 Contact details

Telephone numbers: Work ______ Cell ______ Fax ______

Home ______

Email address

4.2 Medical aid details

Medical aid name

Medical aid number

Date joined / /

4.3 Other information

4.3.1 What is your highest academic, professional or trade qualification? ______

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

4.3.3 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 tots

4.3.4 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:

4.3.5 Do you currently practice any avocations e.g. scuba diving, flying, etc.? ☐ Yes ☐ No

If "Yes", please provide full details:

4.3.6 Please state the average number of hours that you were working per week, for the three months prior to the date of the claim event.

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

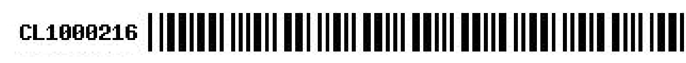
If "Yes", please provide full details of when you partially or fully retired and the reasons for your retirement:

Section 5 – Income details (Compulsory unless the claim is for overhead expenses only)

NOTE: proof of income must be submitted to Liberty at claim stage, unless it was provided at inception, or reinstatement or when the sum assured was increased, excluding annual increases.

Did you submit proof of income to Liberty at inception, reinstatement or when an "adhoc" increase was done to the policy? ☐ Yes ☐No

If "No", please attach proof of income to this claim form. We will be assessing your claim according to your after-tax insurable monthly income as defined in the terms and conditions of your policy.



5.1 Salaried persons

5.1.1 Please state your taxable income for the 12 months immediately prior to the date of disability or impairment.

R ______________________

5.1.2 Cost to Company for 12 months immediately prior to date of disability or impairment.

R ______________________

5.2 Self- employed individuals and individuals in partnerships

5.2.1 Please state your total earnings for the 12 months immediately prior to the date of disability or impairment.

R ______________________

Earnings are defined as monthly fees less the share of cost of sales, less the share of overhead expenses.

5.3 Self- employed (fees based) on professionals

5.3.1 Please state your total fees earned over the past 12 months immediately prior to the date of disability or impairment.

R ______________________

Fees are defined as net fee income less business overhead expenses.

5.4 Commission earner

5.4.1 Please state your basic taxable salary for the 12 months immediately prior to the date of disability or impairment.

R ______________________

5.4.2 Please state your commission earned for the 12 months immediately prior to the date of disability or impairment.

R ______________________

5.4.3 If earning an hourly rate please advise the rate earned per hour for the 12 months immediately prior to the date of disability or impairment.

R ______________________

Section 6 - Medical information relating to your claim

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

____

____

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

____

6.3 Is the medical condition claimed for due to:

☐ Disease ☐ Accident

6.4 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.

____

____

6.5 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

6.6 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

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

____

____

____

Section 7 - Claim information

7.1 Guaranteed Payment Period claims

A Guaranteed Payment Period claim will be admitted and paid, for the number of months specified, if the life assured suffers one or more of the specified Guaranteed Payment Period claim events.

Please mark the relevant claim event you are claiming for:

- ☐ Fracture of collar bone
- ☐ Fracture of forearm
- ☐ Fracture of skull (except bones of the nose or face)
- ☐ Fracture of knee cap
- ☐ Fracture of shoulder blade
- ☐ Fracture of facial bones – Le Forte III
- ☐ Fracture of thigh (femur)
- ☐ Fracture of hind foot (calcaneus, talus, navicularis, cuboid or either of the three cuneiform bones)
- ☐ Fracture of facial bones – Le Forte II
- ☐ Fracture of hand requiring plaster or surgery
- ☐ Hospitalisation for longer than a week
- ☐ Fracture of leg between knee and foot
- ☐ Fracture of upper arm
- ☐ Fracture of pelvis
- ☐ Fracture of spine (compression fracture of more than 50% of the vertebral body or burst fracture)

7.2 Permanent Impairment claims

A Permanent Impairment claim will be admitted once Liberty has established that the life assured is permanently impaired as defined in the policy document and the condition suffered qualifies under the definitions stated in the policy document.

Please mark the relevant category you are claiming for:

- ☐ The cardiovascular system
- ☐ The digestive system
- ☐ The skin
- ☐ The endocrine system
- ☐ The visual system
- ☐ Mental and behavioural disorders
- ☐ The limbs
- ☐ Activities of Daily Living catch-all
- ☐ The respiratory system
- ☐ The urinary system
- ☐ The haemopoietic system (blood)
- ☐ Ear, nose, throat and related structures
- ☐ The central nervous system
- ☐ The spine
- ☐ Cancer

7.3 Occupational Disability and Overhead Expenses Benefit claims

An Occupational Disability claim will only be assessed once Liberty has established that the life assured has been continuously disabled for the full duration of the waiting period, as defined in the policy document.

7.3.1 Name and address of last or present employer:

Name ____________________

Address ____________________ Postal code ________

7.3.2 Length of service with employer ____________________

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

____

7.3.4 Please provide a breakdown of your duties

Administrative %	Supervisory %	Manual %	Travel %

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

____

____

____

7.3.6 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:

____

____

7.3.7 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 specify the countries that you travel to and the nature of your duties in those countries.

____

____

7.3.8 How long have you been following this occupation?

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

Employer	Nature of occupation	Date from	Date to

7.4 Details of your inability to perform your occupation

7.4.1 Has your medical condition impacted on your ability to perform your occupation? ☐ Yes ☐ No

If "Yes", please provide full details:

7.4.2 On what date were you last able to work?

7.4.3 On what date do you expect to return to work?

Full time ☐ Yes ☐ No Part time ☐ Yes ☐ No

If "Yes", for "Part time", please provide details on how many hours will you be working per week and when?

7.4.4 Are you currently losing an income due to your medical condition? ☐ Yes ☐ No

If "Yes", please provide full details i.e. sources of income lost as well as what percentage of the income has been lost.

7.4.5 On what date did you last receive a full income?

7.4.6 Have you received any income or any benefits since the above date? ☐ 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	

A claim will only be admitted where a loss of income occurs as a result of the disability. Where a loss of income occurs and the medical evidence is sufficient, in Liberty's opinion, to prove that the life assured is unable to perform the duties of their occupation, Liberty will not require proof of loss of income for a period of up to 12 months, or up to 24 months if the life assured is a professional as defined by Liberty. Liberty reserves the right to request any additional or specific medical information it deems necessary to admit a claim on this basis or to continue paying a claim on this basis. This initial period where a proof of loss of income is required will start from the date that the life assured is considered disabled, according to Liberty. In all other circumstances, Liberty reserves the right to request proof of loss of income.

Section 8 - Other benefits

Have you claimed or do you intend claiming for payment of disability, dread disease, impairment or any similar benefit with any other insurance company? If "Yes", please provide details: ☐ Yes ☐ No

Name of company	Policy number	Date of inception	Value of lump sum / amount of monthly payment
			R
			R
			R
			R

Section 9 – 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 10 - 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 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 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

Glossary of terms

PRE-TAX MONTHLY INCOME

Salaried employees

For salaried employees, Pre-tax Monthly Income is defined as the cost to company, earned for the last 12 months. This is the total cost to your employer and includes all benefits associated with employment except for the following: annual bonuses (including 13th cheques), ad-hoc bonuses, leave pay, merit award, share incentive awards, bonus/incentive amount paid to an employee to retain his/her service for a specified period.

Self-employed individuals and partnerships

Pre-tax Monthly Income is defined as the share of the average monthly fees (and sales) earned, less the share of cost of sales, less the share of overhead expenses (where fees earned and costs incurred are shared on a pro-rata basis) earned over the last 12 months.

Self-employed professionals

For professionals that charge a fee for services, Pre-tax Monthly Income equals the average monthly sum of the professional fee and the net income from trading activities, after deducting business overhead expenses over the last 12 months.

Post-tax monthly income

Post-tax monthly income is the Pre-tax monthly income defined above less the tax payable on taxable income receivable on account of the Life Assured's employment, or any services rendered by the life assured.

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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.

From claimant statement signed by life assured:
"I hereby authorise any medical practitioners, hospitals, clinics, medical aid schemes, pathology, pharmacies, SARS, any other financial institution 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.

Thanking you in anticipation.

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.

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 2 - Claimant details

Policy number/s

Surname

First name — Initials

ID number

Date of birth __ __ / __ __ / __ __ __ __

Occupation, including discription of duties

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

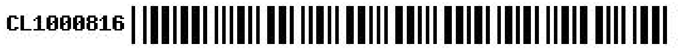
3.11 Symptoms of current condition

3.12 Clinical details indicating severity and permanence of current condition

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

3.14 Treatment and response

3.15 Any other treatment options available



3.16 How often does he/she require treatment? ____________________

3.17 Is the life assured compliant with the treatment routine? ☐ Yes ☐ No

If "No", please provide full details:

3.18 Please provide any additional comments:

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 Current major complaints ____________________

Section 5 - Is the current medical condition/impairment due to:

5.1 Previous illness or injury? ☐ Yes ☐ No

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

5.3 Attempted suicide or any self inflicted injury? ☐ Yes ☐ No

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

If "Yes", please provide full details: ____________________

Section 6 - Prognosis

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

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

6.3 At what time will you be able to establish that residual problems are permanent? ____________________

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

6.5 Is this form completed after an examination or from records? ____________________

Date of records ____________

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

6.7 If "No", please provide reason:

Section 7 - Permanent inability to perform basic ADL and instrumental ADL’s

Activity	Description	Current limitations				Expected future ability		
Basic ADL’s		Non	Mild	Moderate	Impossible	Improve	Remain constant	Deteriorate
Washing	The ability to wash oneself without physical assistance or supervision, this included transferring in and out of the bath or shower	☐	☐	☐	☐	☐	☐	☐
Dressing	The ability to independetly put on or take off all garments, including the security and unfastening therof. Where appropriate, this includes any braces, prosthesis or other surgical procedures.	☐	☐	☐	☐	☐	☐	☐
Feeding/eating	The ability to eat independently once food has been prepared and made available.	☐	☐	☐	☐	☐	☐	☐
Continence	The ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained.	☐	☐	☐	☐	☐	☐	☐
Transferring	The ability to independently transfer from the bed to a chair with the assistance of a walking aid	☐	☐	☐	☐	☐	☐	☐
Instrumental ADL’s								
Telephone use (communication)	The ability to use a telephone indepently, ths includes answering the phone on an incoming call, being able to hold a basic conversation, as well as the ability to dial a well known or written down number.	☐	☐	☐	☐	☐	☐	☐
Food preparation	The ability to prepare and serve simple, everyday meals. This includes the ability to perform simple measurements, preparation activities and having awareness of general kitchen safety.	☐	☐	☐	☐	☐	☐	☐
Housekeeping	The ability to perfom light household chores susch as making a bed, washing dishes and maintaining a reasonable level of cleanliness.	☐	☐	☐	☐	☐	☐	☐
Transport	The ability to safely drive a car (including getting into and out of the car) or the ability to use public transport including being able to provide a drop-off address, and reaching a public transport pick up point.	☐	☐	☐	☐	☐	☐	☐
Handling finances	The ability to perform basic calculations such as purchasing daily consumables, including the ability to perform a basic calculation of what money is required to pay for purchases and what change is due.	☐	☐	☐	☐	☐	☐	☐
Writing	The ability to take down a simple message or complete a simple form requiring personal details such as name, date or birth and address.	☐	☐	☐	☐	☐	☐	☐

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 8 - Treatment and rehabilitation

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

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

8.3 Planned future treatment, including surgery:

8.4 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 9 – 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.

CL1001116

LIBERTY

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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.**

CL1001216

LIBERTY

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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 %

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

3.5 Has he/she been medically boarded or were his/her services terminated?

Official boarding date/date services terminated

Reasons for termination

3.6 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

3.7 Until what date is renumeration expected to be paid?

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

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

If "Yes", please provide deetails:

3.10 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.**

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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 employer/designated person

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

OVERHEAD EXPENSES BENEFIT

Section 1 - Personal details

Policy number/s

Surname

First name | Initials

ID number

Section 2 – Company details

Name

Registration number

Contact number | Fax number

Email address

Website page

Physical address

Postal code

	Type of an organisation and percentage of shareholding	
☐	Sole Proprietor	%
☐	Partnership or other non-incorporated organisation	%
☐	Close corporation	%
☐	Company	%

Your position in the company

Is there any other person in the organisation that is able to perform your profession or trade in your absence? ☐ Yes ☐ No

If "Yes", please provide details:

Section 3 – Breakdown of overhead expenses that are allowed to be claimed (Please attach income and expenditure form)

Overhead expenses	Expenses for past 12 months
Salaries and/or wages of employees (Salaries of members of life assured's immediate family, persons in the same profession, trade, business associates, persons performing the same duties are excluded).	R
Rent on business premises (that the Commissioner of Inland Revenue allows as a deduction).	R
Electricity, water, telephone	R
Regular maintenance services	R
Property taxes and mortgage interest payments on business premises.	R
Leasing costs of equipment that is an essential feature of the business.	R
Insurance premiums (business)	R
Accounting fees	R
All other fixed expenses, which are normal and necessary in conducting the business and have been declared to and accepted by Liberty.	R

The following overhead expenses are not included:
Depreciation, salaries to members of your immediate family, or profession or trade, or business associates, or any person performing your duties in your absense, fees, drawings, any remuneration for yourself, additions to the inventory, the cost of any type of goods or merchandise, the cost of furniture or equipment or other expenditure on assets, capital repayment on outstanding debt and expenses recoverable under any disability insurance.

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 - Declaration

I 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 facts from Liberty. I warrant that I am authorised to provide this information to Liberty.

I acknowledge and agree that any benefits payable in respect of this claim shall be forfeited if, or anyone acting on my behalf or with my knowledge or consent, have knowingly withheld any material fact 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 form all liability in respect of such benefit.

Signed at ____ on ________________________

______________________________ ______________________________

Signature of policyholder Signature of life assured