



Liberty Corporate – A division of Liberty Group Limited Reg. No. 1957/002788/06  
An Authorised Financial Services Provider (Licence No. 2409)  
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For claims forms: [E lcb.customerservices@liberty.co.za](mailto:lcb.customerservices@liberty.co.za) f +27 (0)11 408 2158  
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## MEMBER'S STATEMENT

To be completed by you, the member of the scheme. Should you be unable to do complete this form, please advise the Disability Claims team. Please answer each question clearly with as much detail as possible – do not use a dash, correcting fluid or leave any fields blank. If not applicable, please write N/A.

Member's full name: \_\_\_\_\_ Member number: \_\_\_\_\_  
Scheme name: \_\_\_\_\_  
Scheme number: \_\_\_\_\_  
Employer's name: \_\_\_\_\_  
Member's residential address: \_\_\_\_\_  
Postal address: \_\_\_\_\_  
Telephone number: (h) \_\_\_\_\_ (w) \_\_\_\_\_  
Cell number: \_\_\_\_\_ Email address: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ **Please attach proof of age e.g. certified copy of I.D. document or passport.**

**Benefit/s being applied for (Please tick the appropriate box):**

- |  |   |
|--|---|
| <input type="checkbox"/> Occupational Capital Disability | <input type="checkbox"/> Progressive Capital Disability |
| <input type="checkbox"/> Occupational Income Plus Plan   | <input type="checkbox"/> Progressive Income Plus Plan   |

### OCCUPATION

A) What was your main occupation immediately before the current impairment commenced? \_\_\_\_\_  
B) What were the exact duties involved in your main occupation immediately before the current impairment commenced?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
C) For how long have you followed this occupation? \_\_\_\_\_  
D) Have you changed your occupation (even if temporarily)? \_\_\_\_\_  
E) Other occupations (if any) and for what periods? \_\_\_\_\_  
F) What are your academic and/or technical qualifications? \_\_\_\_\_  
G) On which date were you last able to undertake any form of work? \_\_\_\_\_

### DETAILS RELATING TO IMPAIRMENT

A) What is the diagnosis of your condition? \_\_\_\_\_  
B) When did this problem start? \_\_\_\_\_  
C) Have you had a history of similar problems in the past? Please provide details:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
D) What treatment did you receive? \_\_\_\_\_

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.**

E) What is it about your medical problem that prevents you from working? \_\_\_\_\_

F) Please provide details of any doctors, clinics or institutions consulted regarding your current impairment or any other illness or injury in the five-year period prior to the commencement of your current impairment? If insufficient space, use a separate sheet.

Name of Doctor or Institution	Telephone number	Reason for consultation	Date of consultation

G) Have you had any tests or X-rays? Provide details: \_\_\_\_\_

H) Have you been confined to bed, house, hospital or nursing home? If so, state which and provide dates. \_\_\_\_\_

I) Has there been any improvement in your condition? If so, please describe. \_\_\_\_\_

J) Did your impairment result from an accident? \_\_\_\_\_

K) Have you resided or travelled abroad for more than thirty days in the last twelve months? If so, please provide details. \_\_\_\_\_

**DAILY ACTIVITIES**

- Do you do shopping?  Yes  No    Can you walk?  Yes  No    Can you wash yourself?  Yes  No
- Can you put your shoes on?  Yes  No    Do you watch television?  Yes  No    Do you travel?  Yes  No
- Do you drive?  Yes  No

Provide details of any other activities: \_\_\_\_\_

## INCOME DETAILS

- A) What was your taxable income for the last tax year? \_\_\_\_\_
- B) How much of this amount was derived from your main occupation? \_\_\_\_\_
- C) Can you produce a tax assessment to substantiate this income? If so, please attach copy. \_\_\_\_\_
- D) What was your monthly salary prior to your date of disablement? \_\_\_\_\_
- E) What is your marital status? \_\_\_\_\_ F) No. of dependants: \_\_\_\_\_
- G) Have you received any income since you stopped working?  Yes  No If yes, please provide details: \_\_\_\_\_

Amount of income	Source of income

- H) Have you ever received any disability benefits from this scheme?  Yes  No If yes, please provide details: \_\_\_\_\_

- I) Do you have any other policies with provision for disability benefits, or will any benefit be payable to you (apart from medical aid) from any other source, fund or company by virtue of your impairment? If so, give details providing name of fund or company, amount of benefit, policy numbers etc. (NB: UIF benefits payable must be included)

## DECLARATION

I, the undersigned, \_\_\_\_\_ (please print your full name)

hereby notify LIBERTY CORPORATE, that by reason of the impairment described herein, I have been incapacitated, thereby prevented from pursuing my occupation for remuneration or profit. I therefore make claim for payment of benefits under the above scheme.

Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks, and the consideration of any claim for benefits, under a policy related to this or any other proposal for insurance made by me, or in respect of me as life assured, I irrevocably authorise LIBERTY CORPORATE –

- (a) to obtain from any person or institution, whom I hereby so authorise and request to give, any information which LIBERTY CORPORATE deems necessary, and
- (b) to share with other insurers that information and any other information contained in this proposal or in any related policy 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 LIBERTY CORPORATE or by the operators of such data base.

I hereby declare and warrant that I am an active member of the abovementioned scheme, that the impairment was not due in any way to self-inflicted injury, and that the answers given in this claim form are in every respect true and correct and that no material information has been withheld nor details of any relevant circumstances omitted.

I am not insolvent

Signed at \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Witness's signature

\_\_\_\_\_  
Member's signature

**IMPORTANT:** If the member is unable to sign, the member's signature must be represented by a thumbprint and a Commissioner of Oaths must complete this form in conjunction with an "Identification and Declaration Confirmation" form.

## Complaints procedure

Our complaints handling procedure guide is available on our website, [www.liberty.co.za](http://www.liberty.co.za), or we can send it to you on request.

Complaints or comments regarding the claim should be directed in writing to:

**The Complaints Resolution Manager**

Liberty Corporate

P O Box 2094, Johannesburg, 2000

Email address [contactlcb@liberty.co.za](mailto:contactlcb@liberty.co.za)

Tel number +27 (0)11 408 2771

Fax number +27 (0)11 408 4440

**OR The Liberty Internal Adjudicator**

P O Box 10499, Johannesburg, 2000

Email address [internaladjudicator@liberty.co.za](mailto:internaladjudicator@liberty.co.za)

Fax number +27 (0)11 408 4195

If the complaint is not resolved to your satisfaction by Liberty, you may contact one of the legislative bodies that have been tasked to look after your interests.

**For fund complaints**

The Pension Funds Adjudicator

P O Box 580, Menlyn, 0063

Email address [enquiries-jhb@pfa.org.za](mailto:enquiries-jhb@pfa.org.za)

Tel. number +27 (0)12 346 1738

Fax number 086 693 7472

**OR For complaints regarding a financial adviser**

FAIS Ombudsman

P O Box 74571, Lynnwood Ridge, 0040

Email address [info@faisombud.co.za](mailto:info@faisombud.co.za)

Tel. number +27 (0)12 470 9080

Fax number +27 (0)12 348 3447