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

RETRENCHMENT 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
- **Post:** PO Box 10499, Johannesburg, 2000

Retrenchment is defined as the termination of employment of the life assured in terms of section 189 and 198A of the labour relations act (1995), as amended.

This claim is for a:

☐ **RETRENCHMENT PROTECTOR**

☐ **RETRENCHMENT PREMIUM WAIVER**

Standard requirements – please attach copies of the following documents

☐ Initial letter/communication of intention to retrench.
☐ Most recent pay advice.
☐ Retrenchment letter from employer.
☐ UI19 (stamped and dated by the UIF).
☐ UI6A (monthly).
☐ PMA (Liberty will call the doctor directly).
☐ Certificate of service and/or letter of employment.
☐ Copy of life assured's ID document or copy of the back and front of ID smart card.

Liberty reserves the right to call for additional requirements where necessary.
FAILURE TO RECEIVE ALL THE REQUIREMENTS WILL DELAY THE CLAIM PROCESS.
Please complete all questions - do not make reference to other documents (n/a is not an acceptable answer).

Section 1 - Financial adviser contact details

The contact person for this claim is:

Title ________ First names ____________________

Surname ____________________

Contact numbers: Work ____________ Cell ____________ Fax ____________

Email address ____________________

Consultant code ____________________

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

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

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 ____________________ Race: ☐ Black ☐ White

Email address 2 ____________________ ☐ Coloured ☐ Indian/Asian

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 (retrenched)

(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

Race: ☐ Black ☐ White ☐ Coloured ☐ Indian/Asian

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

3.1 Contact details

Contact numbers: Work ________ Cell ________ Fax ________

Home ________

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 Doctor's details

Please provide the details of all doctors that you have consulted during the past 5 years:

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

Section 4 – Employment details

Name of employer ______________________

Physical address ______________________

______________________ Postal code ________

Contact number ______________________ Fax number ________

Email address ______________________

Occupation ______________________

Period of employment: From ________ To ________

Effective date of retrenchment ________

Please provide the employment contract basis: ☐ Full time **OR** ☐ Part time ☐ Fixed term ☐ Temporary/adhoc

4.1 Previous employment details

Name of employer ______________________

Contact number ______________________ Fax number ________

Email address ______________________

Number of years in service ________

Section 5 – Banking details (excluding credit card) - Not applicable for Retrenchment Premium Waiver

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 6 – 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

____________________ Name of policyholder

____________________ Signature of life assured

____________________ Name of life assured

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TO BE COMPLETED BY THE EMPLOYER

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 - Employee's details

Title ______ First names ______
Surname ______
ID number ______
Employee number ______ Position in company ______

Section 2 - Employer's details

Company name ______ Company registration number ______
Contact number ______ Fax number ______
Email address ______
Physical address ______ Postal code ______

Section 3 - Employment details

Period of employment: From ______ To ______
On what date was the company advised of potential retrenchment? ______
Was it written or verbal (tick both) if written, (please attached copies to the declaration). ☐ Verbal ☐ Written
On what date was this specific employee advised of their retrenchment? ______
Please provide the employment contract basis: ☐ Full time **OR** ☐ Part time ☐ Fixed term ☐ Termporary/adhoc
Reason for termination: ☐ Ill health/ /boarded ☐ End of term ☐ Voluntary retrenchment ☐ Involuntary retrenchment
☐ Other, provide details: ______

Section 4 - Employer's declaration

I (full name and surname) ______
hereby declare that I am the person designated and authorised by the abovementioned 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.

Signed at ______ on ______

______ Signature of designated person

______ Designation

Company stamp

Important information

Why do we call for PMA and/or other medical history on retrenchment protector claims?

The information in the PMA is used to assess both the medical and the contractual validity of the claim, irrespective of the reason for the claim or the benefit claimed. This means that we require a PMA to determine the contractual validity of Retrenchment Protector claims as well, even though the claim itself may have nothing to do with the health of the life assured.

If insurers do not assess the contractual validity at the first claim event, they potentially risk losing the ability to assess it in the future as well. This means that they could be forced to pay future claims on policies where non-disclosure is present. Being forced to pay claims that are not truly valid will potentially have a negative impact on the future premiums that would need to be paid by all other policyholders.

Why do we ask for a UI6A?

One of the conditions of the policy is to provide proof of unemployment on a monthly basis through registration as an unemployed individual with the Unemployment Insurance Fund (UIF) in order to claim and continue claiming under the benefit. The UI6A form is an official document given by the UIF department when claims are lodged with them. The claimant will either have to go to their UIF department or submit a claim via UFiling in order to get this UI6A form.

Benefit information

Once retrenched, the life assured needs to provide proof of unemployment on a monthly basis through registration as an unemployed individual with the UIF in order to claim and continue claiming under the benefit.