

How to claim

Two forms are Required for the submission of a disability claim:

1. Disability Claim Form - Claimant & Employer (to be completed by the claimant and employer)
2. Disability Claim Form - Medical Attendant's Report (to be completed by the claimant/employer and the medical attendant).

The form is structured into the following sections:

Section A: To be completed by the claimant and employer.

Section B: To be completed by the claimant.

Section C: To be completed by the employer.

Section D: To be completed jointly by the claimant and employer.

This fully completed form should be accompanied by the following supporting documentation:

- *an original certified copy of the claimant's identity document or passport
- *a copy of the claimant's payslip for the last completed month of employment
- *a copy of the claimant's job description
- *a copy of the claimant's sick leave records
- *copies of any medical certificates on file with the employer
- *proof of continuous premium payment during the waiting period
- *proof of banking details
- *accident report if applicable

Section A (to be completed by the claimant and employer)

Scheme Details:

Employer:	
Policyholder:	
Policy number:	

Employer's Details

Name of Company:			
Physical Address:		Postal Address:	
Contact Person:		Job Title:	
Telephone Number:		Email Address:	

Main Member's Personal Details

First Names:		
Surname:		
Identity/Passport Number:		
Date of Birth:	Y Y Y Y M M D D	Gender: ☐ Male ☐ Female
Residential Address:		Postal Address:
Home Telephone Number:		Cellphone Number:
E-mail Address:		
Occupation:		

Banking Details

Please indicate whether the lump sum benefit (if accepted) should be paid to the employer or the fund? ☐ Employer ☐ Fund

Employer Bank Details:

Name of Account Holder:		
Name of Bank:		
Branch		Branch Code:
Account Number:		Account Type:

Fund Bank Details (if lump sum payment is to be made to fund):

Name of Account Holder:		
Name of Bank:		
Branch		Branch Code:
Account Number:		Account Type:

Section B (to be completed by claimant)

Claimant's Report on Employment

What is your current position?	
What date did you start in your current position?	Y Y Y Y M M D D
What date were you last able to perform fully in your current position?	Y Y Y Y M M D D
What date did you stop working?	Y Y Y Y M M D D
Have you been able to perform any of your main occupational duties since the onset of your condition?	☐ Yes ☐ No
If "Yes", please provide details including dates, and a description of your occupational duties and remuneration.	
Date	Y Y Y Y M M D D
Description	
Date	Y Y Y Y M M D D
Description	
Date	Y Y Y Y M M D D
Description	
Date	Y Y Y Y M M D D
Description	

Claimant's Report on Employment continue

Have you been able to perform in any other occupation since the onset of your condition?

☐ Yes

☐ No

If "Yes", please provide details including dates, and a description of your occupational duties and remuneration.

Date

Description

Date

Description

Date

Description

Date

Description

Are you currently able to engage in any part of your occupation?

☐ Yes

☐ No

If "No", when do you expect that you will be able to participate on a:

Part-time basis?

Full-time basis?

If you are not currently working, when do you expect to be able to resume work on a:

Part-time basis?

Full-time basis?

Claimant's Report on Claim

What do you understand to be wrong with you?

When did you first experience symptoms?

Please describe the symptoms:

Has any one of the following contributed in any way to your condition?

Nature of Contributor

Accident*

☐ Yes

☐ No

Previous illness or injury

☐ Yes

☐ No

Hazardous pursuit or pastime

☐ Yes

☐ No

Habits (eg excessive alcohol)

☐ Yes

☐ No

Self inflicted injuries

☐ Yes

☐ No

Details if "Yes"

If this claim has arisen as a result of an accident, please provide as much detail as possible. Please ensure that an accident report is attached.

What date did you first consult a medical practitioner in respect of your current condition?



Claimant's Report on Claim continue

Please provide details of the first medical practitioner consulted:

Name:	
Telephone Number:	
Address:	

Have you ever suffered from any other form of impairment or ever been declared disabled from employment before? ☐ Yes ☐ No

If "Yes", please provide details:

Date	Y Y Y Y M M D D
Description	
Date	Y Y Y Y M M D D
Description	
Date	Y Y Y Y M M D D
Description	
Date	Y Y Y Y M M D D
Description	

Please provide the name, address and telephone number of your usual family doctor:

Name:	
Telephone Number:	
Address:	

Please provide the names, addresses and telephone numbers of all other medical practitioners including specialists consulted in connection with this condition

Name:	
Type of Practice:	
Telephone Number:	
Address:	

Name:	
Type of Practice:	
Telephone Number:	
Address:	

Name:	
Type of Practice:	
Telephone Number:	
Address:	

Claimant's Report on Claim continue

Name:	
Type of Practice:	
Telephone Number:	
Address:	

Name:	
Type of Practice:	
Telephone Number:	
Address:	

Have you ever been referred to any health care professionals e.g. Physiotherapist, Occupational Therapist, Psychologist or other medical specialists?

☐ Yes

☐ No

If "Yes", please provide details:

Name		Type of practice / Speciality	
From	Y Y Y Y M M D D	To	Y Y Y Y M M D D
Treatment			
Outcome			

Name		Type of practice / Speciality	
From	Y Y Y Y M M D D	To	Y Y Y Y M M D D
Treatment			
Outcome			

Name		Type of practice / Speciality	
From	Y Y Y Y M M D D	To	Y Y Y Y M M D D
Treatment			
Outcome			

Name		Type of practice / Speciality	
From	Y Y Y Y M M D D	To	Y Y Y Y M M D D
Treatment			
Outcome			

Name		Type of practice / Speciality	
From	Y Y Y Y M M D D	To	Y Y Y Y M M D D
Treatment			
Outcome			



Claimant's Report on Claim continue

Have you ever had any tests, X-Rays or special investigations relating to your condition or any other impairment? ☐ Yes ☐ No

If "Yes", please provide details:

Date	Y Y Y Y M M D D
Doctor/Hospital	
Investigation done	
Outcome	

Date	Y Y Y Y M M D D
Doctor/Hospital	
Investigation done	
Outcome	

Date	Y Y Y Y M M D D
Doctor/Hospital	
Investigation done	
Outcome	

Date	Y Y Y Y M M D D
Doctor/Hospital	
Investigation done	
Outcome	

Date	Y Y Y Y M M D D
Doctor/Hospital	
Investigation done	
Outcome	

How has your condition been treated?

Date	Y Y Y Y M M D D
Therapy/Medication	
Description/Dosage	

Date	Y Y Y Y M M D D
Therapy/Medication	
Description/Dosage	

Date	Y Y Y Y M M D D
Therapy/Medication	
Description/Dosage	



Claimant's Report on Claim continue

Date

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Therapy/Medication

Description/Dosage

Date

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Therapy/Medication

Description/Dosage

Date

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Therapy/Medication

Description/Dosage

Date

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Therapy/Medication

Description/Dosage

Date

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Therapy/Medication

Description/Dosage

Date

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Therapy/Medication

Description/Dosage

Date

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Therapy/Medication

Description/Dosage

Date

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Therapy/Medication

Description/Dosage

Date

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Therapy/Medication

Description/Dosage

Claimant's Report on Claim continue

Date

Therapy/Medication

Description/Dosage

Date

Therapy/Medication

Description/Dosage

Date

Therapy/Medication

Description/Dosage

Date

Therapy/Medication

Description/Dosage

Date

Therapy/Medication

Description/Dosage

Date

Therapy/Medication

Description/Dosage

Is future surgery planned / reQuired / anticipated?

☐ Yes☐ No

If "Yes", please provide details:

Has there been any improvement in your condition?

☐ Yes☐ No

If "Yes", please provide details:

Claimant's Report on Claim continue

Activity	Description	Can	With Help	Cannot
Washing	The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.	☐	☐	☐
Mobility	The ability to move indoors from room to room on level surfaces.	☐	☐	☐
Transfer	The ability to move from a bed to an upright chair or wheelchair and vice versa.	☐	☐	☐
Dressing	The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs, or other surgical appliances.	☐	☐	☐
Eating	The ability to feed oneself once food has been prepared and made available.	☐	☐	☐
Toileting	The ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate. The maintenance of continence is included in this activity of daily living although it may be regarded as an activity of daily living on its own.	☐	☐	☐

Please provide full details of your current daily activities.

Morning Activities:

Afternoon Activities:

Evening Activities:

Have you resided outside your home country in the past year? ☐ Yes ☐ No

If "Yes", please provide details:

Date From Date To

Country

Reason

Date From Date To

Country

Reason

Date From Date To

Country

Reason

Date From Date To

Country

Reason

Claimant's Report on Claim continue

Do you intend to reside outside your home country?

☐ Yes

☐ No

If "Yes", please provide details:

Date From

Date To

Country

Reason

Date From

Date To

Country

Reason

Date From

Date To

Country

Reason

Date From

Date To

Country

Reason

Please provide details of any benefit, salary or remuneration that you have received or expect to received as a result of your incapacity including details of salary, benefits from an insurance company, pension fund, state fund or any other source.

Disability benefit

Name of Company

Your Reference Number:

Amount:

Salary

Name of Company

Your Reference Number:

Amount:

Commission

Name of Company

Your Reference Number:

Amount:

Employer Earnings

Name of Company

Your Reference Number:

Claimant's Report on Claim continue

Pension

Name of Company

Your Reference Number:

Amount:

COVID/WCA Benefit

Name of Company

Your Reference Number:

Amount:

Other insurance

Name of Company

Your Reference Number:

Amount:

Other source 1

Name of Company

Your Reference Number:

Amount:

Other source 2

Name of Company

Your Reference Number:

Amount:

Declaration (to be signed by the claimant)

I, hereby declare that I am the person insured under the scheme mentioned above.

The answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from the insurer.

I agree that all written statements, reports and affidavits submitted in support of this claim shall constitute part of this claim.

I agree that benefits payable in respect of this claim shall be forfeited if I, or any person acting on my behalf with my consent, have withheld any material fact or submitted any false information in respect of this claim, and that the insurer reserves the right to proceed with the appropriate action against the claimant.

Accepting that I am there by curtailing my right of privacy, but to facilitate the consideration of my claim I irrevocably authorise the insurer to obtain from any person, whom I hereby so authorise and request to give, any information which the insurer deems necessary.

I authorise any medical practitioner, hospital or other person to provide the insurer with any information that they may require relating to my medical history, my injury, my employment history and/or any other information which may be necessary for the insurer's consideration of my claim.

I also agree that any information provided by me may be verified against other sources or databases.

Signed at (place) on this day of 2 0

Claimant's name Signature

In the event that the form was completed on behalf of the claimant:

Caretaker's name Signature

OR

Employer's name

Signature



Section C (to be completed by the employer)

Employer's Report

When did the claimant join the company?

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

When did the claimant join the disability benefit scheme?

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Is the claimant a full-time employee?

☐ Yes ☐ No

Date appointed as a full time employee?

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Month last risk premium was paid for?

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

When was the claimant last able to perform his / her duties in full?

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Is the claimant still working?

☐ Yes ☐ No

If "Yes", please provide details of current activities:

--

What was the claimant's salary as at the date that the claimant was no longer able to fulfil the requirements of his / her occupation:

N\$

--	--	--	--	--	--	--	--

What was the effective date of this salary?

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Is the claimant still receiving a salary?

☐ Yes ☐ No

If different from the salary declared above, please advise from which date this new salary was applicable and the reason for the difference?

Reason:

--

Date:

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Until what date do you intend to pay the claimant this salary?

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

When do you expect the claimant to resume work on a:

(a) Part-time basis?

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

(b) Full-time basis?

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

What do you understand to be affecting the claimant's ability to perform the duties of his / her current occupation?

--

At what date was the claimant first unable to perform his / her duties?

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

How is the performance of the claimant's occupational duties being affected by his / her condition?

--

What other alternative occupations within the company would the claimant be capable of performing?

--

If this claim has arisen from an accident at work, please answer the Questions below: Where

did the accident occur?

--

When did the accident occur?

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

Please provide a description of your understanding of how the accident happened?

--

Please provide details of any benefits, salary or remuneration received by the claimant from whatever source (eg from you the employer, an insurance company, a fund or any other source.

Disability benefit

Name of Company	
Your Reference Number:	
Amount:	N\$



Employer's Report continue

Salary

Name of Company

Your Reference Number:

Amount:

Commission

Name of Company

Your Reference Number:

Amount:

Employer Earnings

Name of Company

Your Reference Number:

Amount:

Pension

Name of Company

Your Reference Number:

Amount:

COVID/WCA Benefit

Name of Company

Your Reference Number:

Amount:

Other insurance

Name of Company

Your Reference Number:

Amount:

Other source 1

Name of Company

Your Reference Number:

Amount:

Other source 2

Name of Company

Your Reference Number:

Amount:

Declaration (to be signed by the employer)

Signed at (place) on this day of 2 0

Name and Designation of Authorised Signatory:

Signature for and on behalf of the employer

Company Stamp



Section D (to be completed jointly by the employer and the claimant)

Occupational Information

Please state the claimants current job title or position held: Is

the claimant responsibly for the supervision of any staff?

☐

Yes

☐

No

If "Yes", please state the number of staff supervised:

Apart from the claimant's present occupation, please provide a brief job history, including previous positions the claimant has held within the company.

Date From

Date To

Position held

Type of work done

Date From

Date To

Position held

Type of work done

Date From

Date To

Position held

Type of work done

Date From

Date To

Position held

Type of work done

Please provide details of formal training and any courses attended by the claimant.

Date From

Date To

College or Institution

Nature of training

Grade / Standard achieved

Date From

Date To

College or Institution

Nature of training

Grade / Standard achieved

Date From

Date To

College or Institution

Nature of training

Grade / Standard achieved



Occupational Information continue

Date From Date To

College or Institution

Nature of training

Grade / Standard achieved

Date From Date To

College or Institution

Nature of training

Grade / Standard achieved

Please indicate the job description that would be most applicable to the claimant's position:

- ☐ Managerial
- ☐ Supervisory
- ☐ Clerical
- ☐ Machine operator (eg driving or using a machine to perform a task)
- ☐ Light manual labour (eg physically packing or sorting)
- ☐ Heavy manual labour (eg physically digging or loading)
- ☐ Other (please provide details below)

Please provide a brief summary of the claimant's main duties in his / her current role:

What is the minimum training / education reQuired to perform the claimant's occupation?

- ☐ School Highest grade
- ☐ Technical Diploma
- ☐ Professional Degree
- ☐ On the job training Months
- ☐ Other

Please complete the Questions below on the claimant's work environment.

What percentage of the working day does the claimant work:

Indoors % At heights % Outdoors % At depths %

What is the temperature range in the place of work?

°C

What is the decibel range in the place of work?

db

Is the claimant exposed to any dust while working? ☐ Yes ☐ No

If "Yes", please state the type of dust the claimant is exposed to?

Is the claimant exposed to any fumes while working? ☐ Yes ☐ No

If "Yes", please state the type of fumes the claimant is exposed to?



What are the daily standard working hours? (24h clock)

Week

Start

:

End

:

Weekend

Start

:

End

:



Occupational Information

continue

Is shift work reQuired? ☐ Yes ☐ No

If "Yes", please provide details of alternate shift times:

Start time :

End time :

Start time :

End time :

Start time :

End time :

Start time :

End time :

Please complete the below on the physical demands of the claimant's occupation:

Do the claimant's occupational duties involve any of the following? If "Yes", please provide range.

Lifting weights? ☐ Yes ☐ No

Range of weights lifted: kg

Carrying weights? ☐ Yes ☐ No

Range of weights carried: kg

Pushing weights? ☐ Yes ☐ No

Range of weights pushed: kg

Pulling weights? ☐ Yes ☐ No

Range of weights pulled: kg

Do the claimant's occupational activities involve climbing? ☐ Yes ☐ No

If "Yes", please advise type of climbing (eg stairs, ladders, scaffolding etc)

Please indicate how much time is spent on the following activities during each working day by means of a tick in the relevant column on each line:

Activity	Never	Sometimes	Often	Always	Hours per day
Sitting	☐	☐	☐	☐	:
Kneeling	☐	☐	☐	☐	:
Standing	☐	☐	☐	☐	:
Bending	☐	☐	☐	☐	:
Walking on even terrain	☐	☐	☐	☐	:
Walking on uneven terrain	☐	☐	☐	☐	:
Use of both hands	☐	☐	☐	☐	:
Use of fine coordination	☐	☐	☐	☐	:
Engaging in physical labour	☐	☐	☐	☐	:
Reaching above shoulder height	☐	☐	☐	☐	:
Reaching below shoulder height	☐	☐	☐	☐	:
Working in cramped conditions	☐	☐	☐	☐	:

Where the claimant's occupational duties involve walking please indicate:

Average distance walked over even terrain per day: km

Average distance walked over uneven terrain per day: km

Where the claimant's occupational duties involve manual labour, please specify tasks involved:

What hand tools are used to perform the claimant's occupational duties (eg hammer, screwdriver)

What machines are used to perform the claimant's occupational duties (eg computer, hydraulic lift)



Occupational Information continue

What materials are used to perform the claimant's occupational duties (eg pipes, wood, paint)

What equipment is used to perform the claimant's occupational duties (eg trolleys, scaffolding)

Please describe the minimum mental abilities that a healthy individual requires to perform the claimant's occupational duties by completing the table below:

Abilities Required	Very Often	Often	Seldom	Examples of tasks requiring these abilities
Literacy	☐	☐	☐	
Numeracy	☐	☐	☐	
Memory	☐	☐	☐	
Problem solving	☐	☐	☐	
Decision making	☐	☐	☐	
Specialised knowledge	☐	☐	☐	
Concentration	☐	☐	☐	
Planning	☐	☐	☐	
Calculations	☐	☐	☐	
Administrative tasks	☐	☐	☐	

Please describe the minimum communication skills required to perform the claimant's occupational duties by completing the table below:

Abilities Required	Very Often	Often	Seldom	Examples of tasks requiring these
Speaking	☐	☐	☐	
Writing	☐	☐	☐	
Memory	☐	☐	☐	
Listening	☐	☐	☐	
Reading	☐	☐	☐	
Public speaking	☐	☐	☐	

Please complete the following Question if driving is a component of the claimant's occupational duties.

Type of vehicle(s) driven?

Average distance driven: per day: km per week km per month km

Please complete the following Question if flying is a component of the claimant's occupational duties. Type

of aircraft(s) flown?

Average distance flown per week: km

Average flying hours per week:

Please complete the following Question if diving is a component of the claimant's occupational duties.

Certification:

Average depth per week:

Average number of dives per week

Is any mixed gasses used? ☐ Yes ☐ No

Occupational Information continue

Please complete the following Question if mining is a component of the claimant's occupational duties.

Certification:

Is the claimant involved with blasting or explosives? ☐ Yes ☐ No

If "Yes", please provide details of how the claimant is involved and how often?

What type of mining is undertaken? ☐ Opencast ☐ Underground

If underground, please advise:

How often the claimant goes underground:

Average number of hours spent underground per week:

What activities are performed whilst underground:

Please complete the following Question if going out to sea is a component of the claimant's occupational duties. Seamen's

licence:

How often:

How long:

What activities are performed whilst at sea:

Please provide the details of any known safety hazards in the claimant's occupational duties:

Declaration (to be signed by both the employer and the claimant)

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from the insurer.

Signed at (place) on this day of 2 0

Name and Designation of Authorised Signatory:

Signature for and on behalf of the employer

Company Stamp

Signed at (place) on this

day of 2 0

Claimant's name

Signature

In the event that the form was completed on behalf of the claimant:

Caretaker's name

Signature

OR

Employer's name

Signature