



De Beers Income Continuation Scheme: Benefit payment form for disability benefits

**This form must please be completed by the employer and returned to:
Sanlam Corporate: Group Risk - Disability Claims**

Fax number (021) 947-3207

E-mail address EBDisabilityClaimsBenefits@sanlam.co.za

Postal address PO Box 1, Sanlamhof 7532

A copy of this form must be forwarded to HRSS@debeersgroup.com

The person who completes this form, must familiarise themselves with the disability benefit/s that the insured is/are covered for in terms of the policy agreement. Should the claim for the disability benefit/s become payable (after the waiting period and other policy payment stipulations), Sanlam will rely on the information provided in the relevant sections of this form.

Submitting incorrect or insufficient information can lead to incorrect and/or delay of the payment of the disability benefit/s

In terms of the policy agreement, the monthly disability benefit is payable to the employer or the insured.

Please mark the applicable: Employer ☐ Insured ☐

Name and surname of insured _____
 Membership number _____
 Postal address _____
 _____ Postal code _____
 Telephone/ cell phone number _____
 Income tax number of insured _____

Please mark the option with an "X", and complete if applicable

1. Monthly disability benefits payable to an insured:

Note: If the monthly disability benefit is payable to the insured, in terms of the policy agreement, Sanlam can refund the employer for the salary paid to the insured after the waiting period, while the insured was not able to perform his duties. (The refund is limited to the salary, based on the benefit, which the insured qualified for in terms of the policy agreement. To arrange for the refund, Sanlam require the following information:

Did the insured receive a monthly salary from the employer, while on disability? Yes ☐ No ☐

If "Yes", until which date did the insured receive a monthly salary. _____

Should Sanlam refund the salary paid to the insured after the waiting period? Yes ☐ No ☐

Please provide the banking details of the employer, for the refund.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current ☐ Savings ☐ Transmission ☐

If the monthly disability benefits are payable to the insured, please provide the banking details of the insured:

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current ☐ Savings ☐ Transmission ☐

Membership number _____

2. Monthly disability benefits payable to the Employer:

Note: If the policy agreement makes provision for the payment of the monthly disability benefits to the employer, please provide the banking details of the employer.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current ☐ Savings ☐ Transmission ☐

E-mail address where payment advice must be sent to _____

Name and surname _____ Telephone number _____

3. Monthly payment of employer (company) contributions to the fund/employer:

Note: If the policy agreement makes provision for the payment of employer (company) contributions, please provide the banking details of the fund, or the employer's - if payable to the employer.

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current ☐ Savings ☐ Transmission ☐

E-mail address where payment advice must be sent to _____

Name and surname _____ Telephone number _____

4. Monthly deductions of member contributions, from the insured's monthly disability instalment:

Note: If the insured, before he/she became disabled, paid member contributions to the fund, Sanlam can continue deducting contributions from the insured's monthly disability benefit and pay this to the fund. Deducting such contributions is however not in terms of the policy agreement, and therefore the insured's prior consent is required.

Please provide the member contributions percentage, to be deducted from the insured's monthly disability benefit and banking details of the fund.

Member contribution percentage _____ %

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit branch code _____

Type of account: Current ☐ Savings ☐ Transmission ☐

E-mail address where payment advice must be sent to _____

Name and surname _____ Telephone number _____

5. Are there monthly Benefit Society contributions payable? Yes ☐ No ☐

If "Yes", what is the amount payable per month? R _____

Please provide the banking details for the payment of the Benefit Society contributions

Name of account holder _____

Name of bank _____ Name of branch _____

Account number _____ 6-digit code of branch _____

Type of account: Current ☐ Transmission ☐ Savings ☐

6. Does the insured qualify for medical post retirement subsidy? Yes ☐ No ☐

Membership number _____

Declaration

We, the undersigned, declare on behalf of the fund/scheme, that the information provided above is complete and correct.

Signed on behalf of the fund/scheme

Initials and surname _____

Designation _____

Signature _____

Place _____

Initials and surname _____

Designation _____

Signature _____

Date / / (dd/mm/ccyy)