

APPLICATION FOR ILL HEALTH RETIREMENT

CONFIDENTIAL

In terms of Rule A3.4.0 of the Pension Fund:

"A member who, in the opinion of the Employer is considered to be no longer capable of carrying on working as a result of a medical infirmity, may at the sole discretion of the trustees;

- (a) retire in terms of Rule A3.4.2 where the infirmity has resulted in permanent disability precluding further employment or gainful occupation with the Employer or elsewhere;
- (b) retire in terms of Rule A3.4.3 in all other cases."

All the sections of this form must be completed and routed to the various offices as set out below:

Routing

	Date	Initial
Section A - Intimation and motivation		
Section B - Employer detail		
Section C - Employee detail		
Section D - Medical officer's report		
Section E - Declaration by employer		
Section F - Recorded indemnities at Pension Fund		
Section G - Recommendation by Medical Consultant		
Section H - Personnel Consultant's recommendation (Mines only)		
Receipt of form at Pension Fund		

For use by the Pension Fund only

Trustee's decision in terms of Rule			
Approved	Not approved		
Notification to mine / office			

APPLICATION FOR ILL HEALTH RETIREMENT

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Section A - Intimation and Motivation

This application is being initiated by: EMPLOYER ☐ EMPLOYEE ☐ (Tick box)

Full motivation by the initiator of this application:

Comments on the above by the other party:

Signature of Employee: _____ Date: _____

Signature of Employer: _____ Date: _____ Designation: _____

Section B - Employer Detail

Name of mine / office of employer: _____ Fax: _____

Postal address: _____ Code: _____

Section C - Employee Detail

Surname: _____ Policy No: _____ Pay No: _____

First Names: _____ Marital status _____ Date of birth: _____

Revenue office where tax last paid _____ Tax number _____

Date commenced work at present Mine / Office Date joined DBCM group

DBCM working history. (Begin with current position)

Company / Employer	From	To	Occupation / Title	Paterson band
1				
2				
3				
4				

1

2

3

4

Highest educational qualifications: At school Tertiary

Training courses attended:

Course	From	To	At which institution
1			
2			
3			
4			

1

2

3

4

Brief details of current position:

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Section D - Medical Officer's Report

Full name of Medical Officer: _____

Postal address: _____ Code: _____

Are you the applicant's usual Medical Officer? Yes or No ☐

Please list all relevant complaints which may give rise to the claimant being certified as disabled from attending to his/her work.

Please provide details of the severity of each complaint, together with details of treatment and medication, and the prognosis.

Please enclose copies of any tests which were performed.

Nature of complaint or illness. If cause of disability is accidental, please state date and nature of the accident.	State full symptoms and date of occurrences. Please summarise specialist's reports and attach copies.	Severity of condition! Please supply details of any measurements indicating severity. Is there any evidence of permanent damage?	Treatment prescribed. Please indicate degree of control achieved and compliance.	Prognosis
1.				
2.				
3.				
4.				

Section D - Medical Officer's Report Continued

Impact of illness or injury

In order that we may assess the employee's ability to perform various occupations, it would be appreciated if you could indicate to what extent the employee is likely to be able to perform the following activities. If possible, these abilities should be measured relative to what they would have been without the illness or injuries under consideration, ie ignore factors such as the intelligence or natural abilities of the employee.

Activity, task or function	Relative ability to attend to activity. eg. impossible, possible (subject to great / some pain / discomfort) dangrous to himself / others, no limitations, etc.	Is this ability likely to improve, deteriorate or remain constant? If possible, please estimate the period over which any change may take place.
Clerical or administrative work (sedentary occupations)		
Thinking clearly and making decisions		
Interacting with people in the work place, eg. customers, colleagues, etc.		
Supervising other staff		
Walking (non-strenuous) over level ground		
Walking (strenuous) over uneven ground, climbing, working in cramped conditions		
Operating heavy machinery		
Operating light machinery		
Carrying heavy weights		
Carrying light weights eg mail		
Driving a light motor vehicle		
Driving a heavy vehicle, including graders, etc		
Manual labour, eg digging holes, pushing barrows, etc		
Working in a dusty environment, eg a plant or underground		
Performing limited work in a sheltered environment, eg drawing, switchboard, etc		

State whether any of the following contributed in any way to the employee's disability

1. Previous illness, injury, mental or physical defect
2. Hazardous occupations, with DBCM or other employer
3. Hazardous pastimes or pursuits
4. Failure to seek timely medical attention or to heed medical advice
5. Use of alcohol or drugs (other than under medical direction)
6. Willful exposure to peril (other than attempting to save human life)
7. Attempted suicide or any self afflicted injury

Yes or No

If "YES", please give details

Does the employee suffer from a PERMANENT disability precluding further employment or gainful occupation?

Please justify stating medical reasons.

CERTIFICATION

I hereby certify that I have by personal examination, satisfied myself that the above answers are complete and true and that the employee is suffering from the disability as described.

Dated at _____

on this _____ day of _____ 19____

Signed _____

Name, qualifications and address DB/V1/2021
(block letters or rubber stamp)

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Section E - Declaration by Employer

1. Job performance

Which elements of the employee's job can he/she no longer perform?

Is this recent or has it taken some time to develop?

2. Rehabilitation attempts - Alternative employment

Describe any attempts to re-locate the employee in alternative positions. Give details and results.

3. If the disability was as a result of an accident, please state:

Date of accident

Description

Has a claim been made under:

Yes / No

If No, please give reasons

Workmen's Compensation?

Yes	No

Personal Accident Insurance?

Yes	No

4. Further comments by employer

Kindly state any information that may assist the Trustees in their decision.

Signed

Designation

Date

DB/V1/2021

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Section F - Recorded Indemnities

Indemnity recorded

Signed

Date

Section G - Recommendation by medical consultant

1. Comments concerning medical indemnities imposed on employee's membership and impact previous employment may have on his condition.

2. Reason for decision

3. Recommendation

Signed

Date

Section G - Personnel Consultant's Recommendation

Signed

Date

Note: The information disclosed in this document will be treated as confidential and will only be used for the purposes for which it is intended in terms of applicable legislation. The De Beers Pension Fund (the Fund) has accordingly developed a Privacy Policy which covers how the Fund collects, uses, discloses, transfers, and stores members' personal information. Please visit the Fund's website to view the Privacy Policy should you require additional information

