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CLAIM FOR DISABILITY INCOME

Please complete form in block letters.

Policy Number

- An accurately completed form is essential in order to avoid delays in the assessment process. A claim can be considered only if all required documents and all the supplementary statements (as indicated below) have been completed in full and are in Triarc's possession.
- It is also important that you should be aware of the implications of the non-payment/payment of this claim for your financial position, We therefore strongly recommend that at this stage that you should already contact Triarc to assist you in this regard.
- This form and all relevant documents can be sent to us by e-mail, fax or by post. If legible copies of documents are provided to us, the original documents will not be required.

Please supply the following documents:

- Declaration by Employer - Form (if you are not self-employed).
- If you are self-employed, please provide us with proof of the existence of your business, for example audited Financial Statements or Tax Assessments and Statements, Reciepts or Affidavits from persons with whom business has been conducted.
- A copy of your Identity Document.
- Copies of all medical reports including those by which you were medically boarded.
- A report by the treating Specialist (attached).
- SAPS report/reports of injury sustained at work if a claim was by an accident, as well as the result of the investigation if already finalised.

Note: You can only claim for the illness listed in your own contract. If Abroad, provide all medical documentation in English.

Section 1 - Particulars of Insured Life

Surname

Date of Birth d d - m m - y y y y

Full First Names

Contact Details

Telephone Home -

Telephone Work -

Cellphone -

Email

Section 2 - Nature of Claim

1. Stipulate the illness you are claiming for

2. Describe the symptoms you are experiencing and state the date the symptoms began

3. Details of Doctors, Specialists & Consultations you have had regarding the condition you are claiming for.

Name and Surname	Type of Specialist	Telephone	First Consultation

4. If this is NOT your Family Doctor, state the initials, surname, telephone number and address of this Doctor who referred you to the Specialist(s) mentioned above.

Telephone

Section 3 - Medical History

State the initials, surname, address and telephone number of your:

Present Family Doctor

Telephone

Previous Family Doctor

Telephone

Since which date have you been consulting your present Family Doctor? d d - m m - y y y y

Provide the following information with regard to all other Doctors or Specialists you have consulted regarding the condition that gave rise to the claim?

Name of Hospital	Reason for Hospitalisation	Patient Nr.	Admission Date	Discharge Date

Details of Doctors, Specialists and consultations

Name and Surname	Type of Specialist	Address	Telephone	First Consultation

Medical Aid Details

- Name of the Fund
- Membership Number

Other Information

If the illness or injury occured in a country outside South Africa, please provide the following information.

- Country visited
- Reason for visit
- Date of Arrival d d - m m - y y y y Date of Return d d - m m - y y y y
- Date of accident d d - m m - y y y y
- Place of accident
- The disability was caused by ☐ Motor vehicle accident ☐ Accident at Home ☐ Accident at work ☐ Shooting accident ☐ other ☐ Specify

Give a brief description of how the accident happened

If there was an investigation into the cause of the injury or illness, provide the following:

- Name of Police Station
- Case Number
- Initials and Surname of Investigating Officer
- Contact details Telephone - Fax -
- Findings of the investigation (provide copy of the SAPS report//Report of injury sustained at work/Court report)
- Did you suffer any physical loss? Yes ☐ No ☐
- If "Yes", describe the nature of the loss you suffered
- If the loss did not occur on the date of the accident, please state the date on which the loss took place

d d - m m - y y y y

Occupational History

Provide a detailed statement of your career, including your present or last occupation. The exact dates (at least month and year) of the commencement and termination of your service are required.

Employer	Address	Telephone	Commencement	Termination	Type of Work

Occupational History - Continued

What was the last date on which you were actively able to do your work? d d - m m - y y y y

(Not necessarily the date of termination of service)

Date of official discharge d d - m m - y y y y

Describe the most important functions of your occupation(s) from which you earned an income immediately before your disability.

(From the date of official discharge)

State the percentage of time engaged in the actions below as well as the nature of it

Administrative duties	%	
Manual/Physical duties	%	
Supervisory duties	%	
Travelling by car, truck, etc.	%	
Walking and standing	%	
TOTAL	100 %	

(Note: the percentages must add up to 100%)

What is your highest educational qualification? (e.g. Std 10/Gr 12 or B.Com)

At which school or institution did you qualify?

Any other qualifications obtained?

Any skills and/or courses aquired or passed while in service?

Any study area? Business qualifications?

If you are doing any work at present, from which you are earning an income, state the type of work and the income earned

Provide the name, address, telephone and fax numbers of the relevant employer

Telephone - - Fax -

If you are not working at present, do you intend to in the future? Yes No

If "yes", what type of occupation do you have in mind and from which date? d d - m m - y y y y

if "No", in your opinion, what prevents you from performing full-time employment?

Income particulars

What was your gross monthly income during the last 12 months before the onset of your disability? (Please indicate any overtime payment seperately)

Gross R Overtime R

Provide the following information if, owing to or during your disability you are receiving, or are entitled to receive any benefit, income salary, pension or renumeration of any kind (this includes money received from any employer, partner, assurance company, pension or retirement annuity fund, any government fund or from any other source - irrespective of whether a claim has been submitted):

Source of benefit/Name of company	Amount	Frequency	Inception Date	Cessation Date
	R			
	R			
	R			
	R			

What were your sources of income immediately before disability? Please tick the relevant boxes and mention the monthly amounts:

Salary from employer	R		Self employed	R	
Rental income	R		Pension	R	
Investment income	R		Other	R	

Specify other

Important!

Fill in this section only if you were self-employed. Please provide us with proof of existence of your business.

What were your operating costs for the 12 months prior to disability?

What will happen to your business now that you are disabled?

If you are continuing with your business, what is your involvement (e.g. How are you involved in running the business and what is your share of the profit)?

What duties did you carry out before your disability?

What duties do you still do after your disability?

Have you had to appoint people to continue running your business? Yes No

If "Yes", at what cost has this been done? (Please attach documentary evidence such as salary statements.)

Section 4 - Payments

Please note that the payments must be continued until a claim, if any, has been approved

Bank Particulars

Provide us with a copy of your bank statement (not older than three months) on a bank letterhead which indicates the account number and account holders name.

Please complete one of the 2 options provided

1. Payment to the owner of the Policy

- If the claim of the life insured is approved, Triarc is able to make the money available by means of an Electronic Funds Transfer (EFT) to the owner of the Policy. Please provide the following details.

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

Type of Account: Cheque ☐ Savings ☐ Transmission ☐ Other

I the undersigned, hereby declare that the above information is true and correct and confirm that Triarc will not be held liable for any loss that may arise from the use of this information.

Signature of authorised person Date d d - m m - y y y y

2. Proxy and/or payment to a Third Party.

If the Policy owner would prefer that payment of the Claim is handled/received by another person/Institution, please provide us with the following details:

I, (Policy owner) (first names and surname)

Hereby authorise the person indicated below to handle the claim/receive the payment on my behalf and I indemnify Triarc against any and all claims in respect of, and in connection with, the payment by Triarc of the amount(s) concerned to this party. (delete which is not applicable).

(Third Party) (First Names and Surname)

Identity number:

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

Type of Account: Cheque ☐ Savings ☐ Transmission ☐ Other

Signature of Authorised Person Date d d - m m - y y y y

Section 5 - Declaration

I declare that the particulars contained in this form are true and correct. I also irrevocably authorise any Person or Institution, Medical Practitioner, Medical Specialist, Hospital, Nursing Institution or Medical Authority to provide Triarc with any information that may be required regarding my health.

Further, I irrevocably authorise Triarc to share with other insurers that information and any information contained in this proposal or any related plan or other document, either directly or through a database 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 Triarc or by the database operators.

Signature of authorised person

Date d d - m m - y y y y

The Treating Specialist

Important

This report must be completed by a specialist and not a general practitioner.
Before you perform the examination, please determine the client's identity with the help of a photographic proof identity.
Indicate on the report of your findings - what type of proof of identity was given.
The above mentioned insured has required us to consider he/she qualifies for a disability claim.
The assessment of a disability claim is based on two main principals of impairment and disability. The assessment of impairment entails in practical terms, making a diagnosis and then determining on medical grounds which functions the person is still able to perform and which not.On the other hand, disability is a legal process assessing the extent of the person's impairment judges in conjunction with his/her job description, the contract wording and personal factors such as education, experience, etc. To assist us in making this justified decision, we have to be provided with a report regarding the impairment of this person. The decision regarding disability will be made by Triarc.
Please complete the report in accordance with the guidelines set out in the "Guidelines: Medical report on functional impairment'' underneath after you have examined the person.
The insured is responsible for the costs relating to this consultation and medical report.
Guidelines: Medical Report on Functional Impairment
Please use the following only as a guideline to compile your report.

- Diagnosis: (DSM IV for psychiatric conditions)
- Date: Of the onset and course of the disease
- Severity: Perpetual factors, secondary gain
- Current clinical findings: Describe in detail
- Treatment:
  - Treatment modalities
  - Duration of treatment
  - Rehabilitation
  - Types of medication and dosage
  - Theraputic procedures
  - Hospitalisation
- Response to treatment
- Complications that are permanent
- Special Investigations: e.g. ECG, X-Rays, Scans
- Prognosis with optimal treatment
- Influence on lifestyle, activities of daily living and working capability
- Special requirements:
- Cardivascular: NYHA-Classification, excersise capability, stress-ECG, ejection fraction, other
- Respiratory: Dyspnea-grading (ATS), excersise capacity (METS or VO2 max), vitalogram per- and post- inhalation (3 attempts), chest X-Ray, single-breath diffusion test (DCO) in cases of interstital lung disease.
- Orthopaedic: X-Ray and stress views, MRI or CAT scans , other (e.g. Nerve conduction tests)
- Psychiatric: Social functioning, concentration, psychometric tests in cases of cognitive impairment