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TRIARC GROUP RISK

Group Risk Disability Cover Benefit Claim Form - Pre Disability Benefit Assessment

How to complete this form

Please note: This form must be completed by the claimant (if it is medically impossible for the claimant to complete the form, it may be completed by his/her representative or a Curator Bonis*). It is important to note that all questions must be answered fully and may not be left blank or 'deleted' by a line across the space for the answer. The information given must be true and accurate. Any misstatement could be used as a basis for the claim not being considered or jeopardise a fair decision.

A Curator Bonis is a person appointed by the court to manage the finances, property or estate of another person who is unable to do so because of mental or physical incapacity.

If you have any queries, please contact Triarc Group Risk.

Please attach the following:

1. Medical Report (s), accident reports, medical certificates and pre- and post-operation reports
2. Objective evidence for example: Blood test results, CD4 count results, sputum test results, x-ray's, scan reports, histology reports, ECG and ECHO reports.
3. Job description questionnaire
4. Sick leave and attendance records and forms
5. Official boarding

1. Scheme Details

Scheme Name

Policy Number

Postal Address

Code

Contact Person

Initials

Date of Birth

Y Y Y Y M M D D

ID Number

Country of Origin

Designation

Telephone Number

E-mail Address

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2. Details of Member

Surname

First Names

Initials

Date of Birth

Y Y Y Y M M D D

ID Number

Country of Origin

Residential Address

Code

Date of Employment

Y Y Y Y M M D D

When did the member first become eligible for membership of the plan?

Date of Eligibility

Y Y Y Y M M D D

3. Condition Details

Have you submitted a disability benefit claim previously? Yes No

If Yes, please supply details:

What or Who prompted your application for disability?

Date health of member first began to worsen? (if applicable) Y Y Y Y M M D D

Date member first saw a doctor for their illness? (if applicable) Y Y Y Y M M D D

In your own words, describe your medical condition, the cause, major complaints or problems and treatment.

3. Condition Details (Continued)

Indicate any difficulties in activities of daily living, for example washing, dressing, eating, mobility, going to the toilet, self-care etc. that you are currently experiencing.

How does this impairment limit you from performing any particular part of your main duties?

Current treating Doctor's Name

Doctor's Postal Address

Code

Doctor's E-mail Address

Doctor's Telephone Number ( )

Doctor's Fax Number ( )

Have you been admitted to hospital for your condition? Yes No

Name of Hospital (If Yes)

Hospital Telephone Number ( )

Date of Admission Y Y Y Y M M D D

Date of Discharge Y Y Y Y M M D D

3. Condition Details (Continued)

Please state dates, names and contact details of all doctors, specialists, hospitals or clinics consulted in connection with your illness/condition (please provide hospital or clinic reference numbers):

Doctor / Specialist / Hospital

Date	Contact Number	Clinic Reference
Y Y Y Y M M D D		

Other Information

Doctor / Specialist / Hospital

Date	Contact Number	Clinic Reference
Y Y Y Y M M D D		

Other Information

Doctor / Specialist / Hospital

Date	Contact Number	Clinic Reference
Y Y Y Y M M D D		

Other Information

Doctor / Specialist / Hospital

Date	Contact Number	Clinic Reference
Y Y Y Y M M D D		

Other Information

Doctor / Specialist / Hospital

Date	Contact Number	Clinic Reference
Y Y Y Y M M D D		

Other Information

3. Condition Details (Continued)

Doctor / Specialist / Hospital

Date: Y Y Y Y M M D D

Contact Number

Clinic Reference

Other Information

Doctor / Specialist / Hospital

Date: Y Y Y Y M M D D

Contact Number

Clinic Reference

Other Information

Please provide detail of all treatments that you have received, both medical and operations:

Have you suffered any complications of the condition? Please supply details:

If your condition resulted from an accident, please give a brief description of the circumstances surrounding the accident:

What was the date of the accident? Y Y Y Y M M D D

3. Condition Details (Continued)

Please supply the name and contact details of all doctors (including specialists) you have consulted in the last five years:

Doctor/Specialist Name	Contact Number

Have you previously submitted an Income Continuation claim? ☐ Yes ☐ No

If Yes, please supply details:

Have you lodged a similar claim with any other assurance company? ☐ Yes ☐ No

If Yes, please supply details:

Assurer Name	Policy Number

4. Member Information - Occupation and Income

What was your full-time occupation when the condition began?

Have you ever changed your main occupation (even temporarily)? ☐ Yes ☐ No

If Yes, please supply details:

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4. Member Information - Occupation and Income (Continued)

Were you engaging in any other full- or part-time occupation immediately before your condition? ☐ Yes ☐ No

If Yes, please give a short description of the nature and duties of your occupation:

Please specify the percentage of time spent in:

Admin Duties	Manual Duties	Supervisory Details	Driving/Traveling

Are you still physically performing your full-time occupation? ☐ Yes ☐ No

If No: What is preventing you from performing your occupation?

On what date were you last able to perform your occupation due to your illness? Y Y Y Y M M D D

Are you currently performing any other occupation, albeit temporary subsequent to your condition? ☐ Yes ☐ No

If Yes: Please supply the name and contact details of your employer:

Name of Employer	Contact Number

Have you been pensioned or discharged (medically boarded) by your employer? ☐ Yes ☐ No

If No, when do you expect to resume your occupation? Y Y Y Y M M D D

Basis of Return ☐ On Part-time ☐ On Full-time

Please supply your school, academic, professional or trade qualifications:

Have you suffered a loss of income since the onset of your condition? ☐ Yes ☐ No

If Yes, Please supply details:

4. Member Information - Occupation and Income (Continued)

Gross monthly income before the condition	Gross monthly income since the condition
R	R

What is the source of this income?

Did your income fluctuate during the year before the start of your condition?		Yes		No

If Yes, Please supply details:

Average gross monthly income earned (excluding overtime and any other non-pensionable allowances) during the year before your current condition, from:

Your full-time occupation	Any additional occupation
R	R

If you have claimed and/or expect to receive any benefit, income or pension for this period, from any other employer, insurance company, pension/provident fund or from any other source, please specify:

Source of Benefit		
Amount	Type	Payment Date/Commencement
R	Lump Sum / Recurring Payment	Y Y Y Y M M D D

Source of Benefit		
Amount	Type	Payment Date/Commencement
R	Lump Sum / Recurring Payment	Y Y Y Y M M D D

Source of Benefit		
Amount	Type	Payment Date/Commencement
R	Lump Sum / Recurring Payment	Y Y Y Y M M D D

Source of Benefit		
Amount	Type	Payment Date/Commencement
R	Lump Sum / Recurring Payment	Y Y Y Y M M D D

5. Pre-Disability Benefit Assessment Declaration

The answers and statements I have made are true to the best of my knowledge and I have withheld no material fact from Triarc. I authorise any person with any information about my illness or injury to provide such information to Triarc or its representatives to assist Triarc in assessing the condition.

Signed at

Date

Y Y Y Y M M D D

Member's First Name(s) and Surname

Member's Designation

Member's Signature

Employer's First Name(s) and Surname

Employer's Designation

Employer's Signature

Company Stamp

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