

# APPLICATION FOR PAYMENT OF DISABILITY CLAIM



## PARTICULARS OF THE INSURED

Policy Schedule Number

First Names

Surname

Title

Miss Mrs Mr Dr Prof

Initials

Gender

Female

Male

Language

ID / Passport / Card Driving Licence Official Number

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Postal Address

Postal Code

Physical Address

Postal Code

Telephone (w)

Fax (w)

Telephone (h)

Fax (h)

Cellphone

Communication Preference

Post

Fax

e-mail

E-mail address

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Y Y Y Y M M D D

Date of Disability

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Detailed description of cause of disability

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Describe your symptoms and how they affect your ability to perform your occupational duties:

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Have you previously suffered from the same or similar illness?	Yes	No
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If yes, from which date?

Y	Y	Y	Y	M	M	D	D

On what date did the symptoms of the disability, for which you are claiming start?

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From what date have you been totally disabled and unable to follow your normal occupation?

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Which duties of your normal occupation are you not able to do?

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What is your height?	<b>M</b>	Weight	<b>Kg</b>
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**DETAILS OF YOUR FAMILY DOCTOR**

Surname	Initials
Physical Address	
Postal Code	
Telephone (w)	

State names, addresses and dates of all doctors, hospitals and clinics consulted in connection with your condition, (please provide hospital or clinic reference numbers)

<b>A. Doctor</b>	Address	
	Postal code	
Hospital / Clinic	Ref. No.	
Tel Number	Date attended	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Y Y Y Y M M D D

<b>B. Doctor</b>	Address	
	Postal code	
Hospital / Clinic	Ref. No.	
Tel Number	Date attended	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Y Y Y Y M M D D

<b>C. Doctor</b>	Address	
	Postal code	
Hospital / Clinic	Ref. No.	
Tel Number	Date attended	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Y Y Y Y M M D D

Medical Aid Name	Medical Aid Number
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## SECTION B: ACCIDENT DETAILS

Where did the accident take place?

Date of the accident	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Y Y Y Y M M D D
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Nature of accident:

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**1 DETAILS OF WITNESS**

First Name

Surname

Title

Miss Mrs Mr Dr Prof

Physical Address

Postal Code

**2 DETAILS OF WITNESS**

First Name

Surname

Title

Miss Mrs Mr Dr Prof

Physical Address

Postal Code

**DETAILS OF POLICE STATION WHERE ACCIDENT WAS REPORTED**

Name of Police Station

Physical Address

Postal Code

Tel Number

Case Number

Full name, rank and police number of investigation officer:

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Details of any legal action taken as a result of the accident:

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### DETAILS OF THE DOCTOR CONSULTED AS A RESULT OF THE INJURY

Doctor	Initial
Address	
Postal code	
Tel Number	

### SECTION C: EMPLOYER DETAILS

Name of Employer	Employee / Clock No
Employment Address	
Postal Code	
Telephone (w)	Y Y Y Y M M D D
Date when you started working for your current employer	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date when you were last actively able to do this job	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Type of Work	Position Held

Percentage of hours spent on:

Travelling  %    Administration  %    Supervision  %    Manual Labour  %

1. Name of Previous Employer	Employee / Clock No
Employment Address	
Postal Code	
Telephone (w)	Y Y Y Y M M D D
Employed from start date	to end date
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Type of Work	Position Held

Percentage of hours spent on:

Travelling  %    Administration  %    Supervision  %    Manual Labour  %



**SECTION E: DECLARATION AND AUTHORISATION BY THE CLAIMANT**

Policy Schedule Number

**Declaration**

I declare that to the best of my knowledge all the information that I have given in this claim form is accurate and complete and that I have not withheld any information which could influence the decision on this claim. I further declare that I understand that my failure to disclose relevant information in respect of this claim may invalidate the claim.

I acknowledge that I fully understand the contents of this declaration.

**Authorisation**

I hereby authorise Different Life or any of its representatives to obtain any information regarding this policy from any doctor, insurer or elsewhere that may be necessary to investigate this claim. I further authorise Different Life or any of its representatives to release my information regarding this claim to any other interested parties that it deems necessary in respect of this claim.

Signed at \_\_\_\_\_

Signature of Claimant \_\_\_\_\_

Y Y Y Y M M D D

Date

Signature of Commissioner of Oath / Justice of the Peace \_\_\_\_\_

Y Y Y Y M M D D

Date

Official Stamp

**SECTION F: TO BE COMPLETED BY DIFFERENT LIFE**

Policy Number	Commencement date of policy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Y	Y	Y	Y	M	M	D	D

Date Claim received by DIFFERENT LIFE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Y	Y	Y	Y	M	M	D

Details of Claims Committee Decision

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Name	Position
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Signature \_\_\_\_\_