

DISABILITY CLAIM FORM

PARTICULARS OF THE INSURED

Miss Mrs Mr Dr Prof

Female

Male

Post

Fax

e-mail

Y Y Y Y M M D D

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

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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From what date have you been totally disabled and unable to follow your normal occupation?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Which duties of your normal occupation are you not able to do?

What is your height?	M	Weight	Kg
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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)

A. Doctor	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. Doctor	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

C. Doctor	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:

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:

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

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 <input type="text"/> <input type="text"/> %	Administration <input type="text"/> <input type="text"/> %
Supervision <input type="text"/> <input type="text"/> %	Manual Labour <input type="text"/> <input type="text"/> %

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 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	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"/>
Type of Work	Position Held
Percentage of hours spent on:	
Travelling <input type="text"/> <input type="text"/> %	Administration <input type="text"/> <input type="text"/> %
Supervision <input type="text"/> <input type="text"/> %	Manual Labour <input type="text"/> <input type="text"/> %

2. 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	Y Y Y Y M M D D to end date
Type of Work	Position Held

Percentage of hours spent on:

Travelling %
 Administration %
 Supervision %
 Manual Labour %

3. 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	Y Y Y Y M M D D to end date
Type of Work	Position Held

Percentage of hours spent on:

Travelling %
 Administration %
 Supervision %
 Manual Labour %

SECTION D: BANK DETAILS OF THE INSURED

Name of Bank	Branch Name
Account Number	Branch Code
Name of Account Holder	Account Type
Y Y Y Y M M D D 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"/>
Signature of Account Holder	

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 Stangen 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 Stangen 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

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Signature of Commissioner of Oath _____

Y Y Y Y M M D D

Date

--	--	--	--	--	--	--	--	--

Official Stamp

SECTION F: TO BE COMPLETED BY STANGEN

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 STANGEN

<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

Details of Claims Committee Decision

Name

Position

Signature _____