employeebenefits@triarc.co.za | www.triarc.co.za
Phone: 087 231 0222 | Fax: 086 235 5238

Unit 122 The Quays, Park Lane
Century City, 7441

Group Risk Disability Cover Benefit Claim Form - Employee's Declaration

How to complete this form

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

This declaration will form the basis on which the claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Distortion of information could be used as a basis for the claim being declined.

Please attach the following documents:
1. Employer's Declaration
2. Certified copy of Identity Document
3. Confidential Medical Report, with copies of all relevant clinical investigations findings in order to assess the claim

Completed form together with supporting documents to be faxed to 086 235 5238 or email to employeebenefits@triarc.co.za

1. Group Risk Fund Details

Scheme Name

Policy Number

Postal Address

Code

Contact Person

E-mail Address

Designation

Office Telephone Number

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

E-mail Address (Personal)

Telephone Number

Cellphone Number

Have you submitted a Disability Benefit claim before? Yes No

Medical Aid Name

Plan Details

Principle Member's Name

Medical Aid Number

Medical Scheme Monthly Premium R

3. Details of Occupation

Date when you started working for your current employer	Y	Y	Y	Y	M	M	D	D

Date when you started in your current occupation/ position	Y	Y	Y	Y	M	M	D	D

Occupation / Job Title																									

Details of Occupation (Note – a job description must be attached)

Details of duties. List FIVE main performance areas with a brief description of each	
1	
2	
3	
4	
5	

Have you been able to perform part of your job, or another job, since your impairment		Yes		No

If you have performed another job, or if your job was changed, please give details of the job that you did, the date that it changed/started and salary that you were paid.

Normal working hours of job per week	

Normal working days of job per week	

4. Details of Employment History

Apart from your present occupation

Please supply a brief employment history, Most Recent	
Date Started and End Date	
Company	
Position Held	
Type of work	
Salary at the date of leaving	
Reason for leaving	

4. Details of Employment History (Continued)

Please supply a brief employment history, Previous	
Date Started and End Date	
Company	
Position Held	
Type of work	
Salary at the date of leaving	
Reason for leaving	

Please supply a brief employment history, Earliest	
Date Started and End Date	
Company	
Position Held	
Type of work	
Salary at the date of leaving	
Reason for leaving	

5. Qualifications, Training and Experience

	Year Achieved	Standard / Qualification
Highest Level of Schooling		
Technical Qualification (NTC, Diploma, etc)		
Academic Qualifications (Degrees, etc)		
Other Training (e.g. certificates, in-house training, drivers license & codes)		

What alternative occupation/s do you consider yourself qualified for

6. Details of Impairment

Date last able to actively perform your normal occupation	Y	Y	Y	Y	M	M	D	D

Date last able to actively perform an alternative occupation	Y	Y	Y	Y	M	M	D	D

When do you expect to be able to take up any occupation in future?								
On a part-time basis	Y	Y	Y	Y	M	M	D	D
On a full-time basis	Y	Y	Y	Y	M	M	D	D

What is your current employment status? Please tick the appropriate box.					
Working full-time		Laid off		On sick leave	
Working part-time		Retrenched		On unpaid leave	
Other					

If Other, please specify:

List of diagnoses/ symptoms/ complaints								
	Y	Y	Y	Y	M	M	D	D
	Y	Y	Y	Y	M	M	D	D
	Y	Y	Y	Y	M	M	D	D
	Y	Y	Y	Y	M	M	D	D

How does the impairment affect you in doing your normal duties

Which duties can you no longer do

Which duties can you still do

Have you, in the last 5 years, suffered from any serious disease, illness or disablement		Yes		No

If Yes, please provide details:

6. Details of Impairment (Continued)

Details of any hospitalisations within the last 2 years

Date of Admission									Date of Discharge							
Y	Y	Y	Y	M	M	D	D		Y	Y	Y	Y	M	M	D	D

Reason for Admission

Surgery Performed

Date of Admission									Date of Discharge							
Y	Y	Y	Y	M	M	D	D		Y	Y	Y	Y	M	M	D	D

Reason for Admission

Surgery Performed

Date of Admission									Date of Discharge							
Y	Y	Y	Y	M	M	D	D		Y	Y	Y	Y	M	M	D	D

Reason for Admission

Surgery Performed

Date of Admission									Date of Discharge							
Y	Y	Y	Y	M	M	D	D		Y	Y	Y	Y	M	M	D	D

Reason for Admission

Surgery Performed

Date of Admission									Date of Discharge							
Y	Y	Y	Y	M	M	D	D		Y	Y	Y	Y	M	M	D	D

Reason for Admission

Surgery Performed

6. Details of Impairment (Continued)

Current treatment. Please list all medication you are on, provide name and dosage.

Medicine	Dosage
Reason for medication	**Start Date**
	Y Y Y Y M M D D

Medicine	Dosage
Reason for medication	**Start Date**
	Y Y Y Y M M D D

Medicine	Dosage
Reason for medication	**Start Date**
	Y Y Y Y M M D D

Medicine	Dosage
Reason for medication	**Start Date**
	Y Y Y Y M M D D

Medicine	Dosage
Reason for medication	**Start Date**
	Y Y Y Y M M D D

Medicine	Dosage
Reason for medication	**Start Date**
	Y Y Y Y M M D D

Medicine	Dosage
Reason for medication	**Start Date**
	Y Y Y Y M M D D

6. Details of Impairment (Continued)

Please give the names of all doctors, specialists and hospitals you have consulted in connection with your impairment/ disability.

Date of Admission	Date of Discharge
Y Y Y Y M M D D	Y Y Y Y M M D D

Hospital/ Specialist/ Doctor
Speciality:

Telephone Number	Patient Number

Date of Admission	Date of Discharge
Y Y Y Y M M D D	Y Y Y Y M M D D

Hospital/ Specialist/ Doctor
Speciality:

Telephone Number	Patient Number

Date of Admission	Date of Discharge
Y Y Y Y M M D D	Y Y Y Y M M D D

Hospital/ Specialist/ Doctor
Speciality:

Telephone Number	Patient Number

Date of Admission	Date of Discharge
Y Y Y Y M M D D	Y Y Y Y M M D D

Hospital/ Specialist/ Doctor
Speciality:

Telephone Number	Patient Number

6. Details of Impairment (Continued)

Please give name, address and telephone number of your regular family Doctor/ General Practitioner

Name

Telephone Number | **Fax Number**

Physical Address

Code

Since when has he/she been your family Doctor? Y Y Y Y M M D D

Date of your most recent examination? Y Y Y Y M M D D

If you have changed General Practitioners in the last two years, please give details of all previous attending practitioners.

From Date Y Y Y Y M M D D | **To Date** Y Y Y Y M M D D

Doctors Name

Practice Name

Telephone Number | **Patient Number**

From Date Y Y Y Y M M D D | **To Date** Y Y Y Y M M D D

Doctors Name

Practice Name

Telephone Number | **Patient Number**

Please complete if your impairment arose from an accident or other violent means:

Date of accident Y Y Y Y M M D D

What type of accident/ incident occurred

6. Details of Impairment (Continued)

Police station where reported:

Police case number

7. Current Activity Profile

Please indicate your hobbies and interests

Please indicate how you generally spend your day since you have been suffering from the impairment	
06h00 - 07h00	
07h00 - 08h00	
08h00 – 09h00	
09h00 – 10h00	
10h00 – 11h00	
11h00 – 12h00	
12h00 – 13h00	
13h00 – 14h00	
14h00 – 15h00	
15h00 – 16h00	
16h00 – 17h00	
17h00 – 18h00	
18h00 – 19h00	
19h00 – 20h00	
20h00 – 21h00	
21h00 – 22h00	

7. Current Activity Profile

Income prior to your impairment	
Normal salary or wages per month	R
Bonuses or overtime (monthly average last year)	R
Commission (monthly average last year)	R
Other	R

Current or Expected future income

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

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

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

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

7. Current Activity Profile (Continued)

Source of Benefit

Policy Number

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

8. Declaration by Employee

Declaration
I declare that to the best of my knowledge all the particulars given on this claim form are true and correct, and that no material information has been withheld or omitted. I understand that any false and/or misrepresentation of information could be used as a basis for the claim being declined.

Consent to collect and share personal and health information
I hereby consent and authorise:

- Any health practitioner (e.g. medical practitioner, dentist, occupational therapist, psychologist, etc.), allied health practitioner, hospital, medical aid, employer, insurance company, health risk management service provider appointed by my employer or any other person who has information about my health, employment related activities and personal information, to provide such information to Triarc (Pty) Ltd or any 3rd party nominated by Triarc (Pty) Ltd who requires this information for the purposes of assessing my claim.
- Triarc to furnish any medical, occupational and personal information contained in medical reports or otherwise which they have obtained in the course of the assessment of my claim, to a health practitioner, allied health practitioner, health risk management service provider appointed by my employer, or any 3rd party nominated by Triarc who may require such information for the purpose of assisting Triarc in the assessment of my claim or for assessing the payment of a benefit provided for in a risk policy where I am the policyholder.
- Triarc to furnish my employer or its duly appointed intermediary with regular claim status reports which will contain personal information but not any health related information unless I have given my express consent for this information to be provided.

Signed at	Date
	Y Y Y Y M M D D

Signatory First Name(s) and Surname

Signature

9. POPIA Consent Clause - Claim Forms

Processing of Personal Information in terms of the Protection of Personal Information Act 4 of 2013

Your privacy is of utmost importance to Us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner and kept for the period prescribed by the Applicable Laws.

You hereby agree to give honest, accurate and up-to-date Personal Information which may be used for the following reasons:

1. to establish and verify your identity in terms of the Applicable Laws;
2. to enable Us to fulfil our obligations in terms of this Claim;
3. to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the \ Applicable Laws; and
4. reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share your information for further processing with the following third parties, which third parties have an obligation to keep your Personal Information secure and confidential:

1. Payment processing service providers, merchants, banks and other persons that assist with the processing of any benefit payable;
2. Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime;
3. Regulatory authorities, industry ombudsmen, governmental departments, local and international tax authorities, and other persons that we, in accordance with the Applicable Laws, are required to share your Personal Information with; and
4. Credit Bureau's.

You acknowledge that any Personal Information supplied to Us in terms of this Claim is provided according to the Applicable Laws. Unless consented to by yourself, We will not sell, exchange, transfer, rent or otherwise make available your Personal Information to any other parties and you indemnify Us from any claims resulting from disclosures made with your consent.Such Personal Information provided (voluntarily, unconditionally and specifically) will be utilised by Us or by any appointed third parties, on our behalf, and will be kept for such period as legislated according to the Applicable Laws.

You understand that if We have utilised your Personal Information contrary to the Applicable Laws, you have the right to lodge a complaint with Guardrisk within 10 (ten) days. Should Guardrisk not resolve the complaint to your satisfaction, you have the right to escalate the complaint to the Information Regulator.

Signed at	Date
	Y Y Y Y M M D D

Signatory First Name(s) and Surname

Signature