

TRIARC is an authorised financial services provider FSP45009

Group Risk Disability Cover Benefit Claim Form - Job Description

How to complete this form

- This form must be completed by the claimant's immediate supervisor, line manager and or team leader in conjunction with the claimant.
- This job description will form the basis on which the claim is assessed. It is therefore important to note that all questions must be answered accurately, fully, neither left blank or 'deleted' by a line across the space for the answer.
- Should you have any questions or if you need advice, please contact the Triarc Group Risk on 087 231 0222 or employeebenefits@triarc.co.za.

1. Scheme Details

Scheme Name

Policy Number

Contact Person

Designation

Office Telephone Number

E-mail Address

2. General Detail

Surname

First Names

Initials

Date of Birth							
Y	Y	Y	Y	M	M	D	D

ID Number

Country of Origin

4. Work Environment

What percentage and hours per day does the claimant work?

	Percentage	Hours		Percentage	Hours
Indoors			At Depth		
Outdoors			Wet Areas		
At Heights			Dry Areas		

How often is the claimant exposed to the following conditions?

	Always	Sometimes	Seldom	Never	Hours per day
Dust					
Vibration					
Noise					
Fumes					
Heat					
Cold					

Other

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Temperature range in place of work

Decibel range in place of work

Type of Dust and Fumes

Please give details of any safety hazards in the claimants job:

Please list all items, equipment, tools, materials and machinery used:

5. Inherent Requirements / Demands of Work

How often is the claimant exposed to the following conditions?

	Always	Sometimes	Seldom	Never	Hours per day
Sitting					
Standing					
Walking on even terrain (Specify Kilometres per day)					
Walking on uneven terrain (Specify Kilometres per day)					
Kneeling					
Stooping					
Bending					
Crouching					
Squatting					
Climbing					
Use of both hands					
Use of fine co-ordination					
Vision					
Hearing					
Physical strength or power					
Reaching above shoulders					
Reaching below shoulders					

Does the claimant's job involve any of the following?

	Yes	No	How Much?	What?
Lifting Weight				
Pushing Weight				
Carrying Weight				
Pulling Weight				

Only complete this section if driving is a component of the claimant's job

License Code Required	
Type of Vehicle Driven	

Average Distance Driven:

Per Day										Km
Per Week										Km
Per Month										Km

5. Inherent Requirements / Demands of Work (Continued)

Only complete this section if flying is a component of the claimant's job

Type of Aeroplane	
Average Distance flown per week	
Average hours flown per week	

Please indicate how much of the claimant's job requires the following Cognitive Requirements per day

	Always	Sometimes	Seldom	Never	Hours per day
Numeracy					
Calculations					
Memory					
Concentration					
Decision making					
Problem Solving					
Planning					
Judgement					
Insight					

Please indicate how much of the claimant's job requires the following Communication Requirements per day

	Always	Sometimes	Seldom	Never	Hours per day
Verbal Communication					
Written Communication					
Electronic Communication					
Telephonic Communication					
Communication with Clients					
Communication with Colleagues					
Reading					
Listening					
Conflict Resolution					

Is the claimant required to supervise staff and if so how many?

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6. Declaration of Employer

I declare that the answers and statements I have made are true and correct and I have not omitted or withheld any material fact and information from Triarc.

Signed at

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Date

Y	Y	Y	Y	M	M	D	D
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Name and Surname

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Designation

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Company Stamp

Member Signature

Employer Signature

8. POPIA Consent Clause - Employer - Disability

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

The privacy of our Insured 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.

The Insured's Personal Information will be used to assess this disability claim for the Insured.

You hereby agree to give honest, accurate and up-to-date Personal Information of our Insured to assist us in assessing the risk insured against.

You acknowledge that any Personal Information supplied to us in respect of the Insured is provided according to the Applicable Laws.

Unless consented to by yourself, we will not sell, exchange, transfer, rent or otherwise make available any Personal Information you have provided in respect of our Insured unless it is a requirement in terms of the Applicable Laws.

Signed at

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Date

Y	Y	Y	Y	M	M	D	D
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Signatory First Name(s) and Surname

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Signature

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