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TRIARC

GUARDRISK
TAILORED RISK SOLUTIONS

TRIARC is an authorised financial services provider FSP45009

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 to 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 on 087 231 0222 or employeebenefits@triarc.co.za.

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

Designation

Telephone Number

E-mail Address

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 your health began to worsen? (if applicable) Y Y Y Y M M D D

Date you first sought medical attention? (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

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3. Condition Details (Continued)

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

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

Doctor/Specialist Name	Contact Number

Doctor/Specialist Name	Contact Number

Doctor/Specialist Name	Contact Number

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 Insurance company? ☐ Yes ☐ No

If Yes, please supply details:

Insurer 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:

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

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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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6. POPIA Consent Clause - Claim Form

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