TRIARC
GUARDRISK TAILORED RISK SOLUTIONS
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TRIARC is an authorised financial services provider FSP45009

CLAIM FOR DISABILITY INCOME

Please complete form in block letters

Important

- An accurately completed form is essential in order to avoid delays in the assessment process. A claim can be considered only if all required documents and all the supplementary statements (as indicated below) have been completed in full and are in Triarc's possession.
- It is also important that you should be aware of the implications of the non-payment/payment of this claim for your financial position. We therefore strongly recommend that at this stage that you should already contact Triarc to assist you in this regard.
- This form and all relevant documents can be sent to us by e-mail, or by post. If legible copies of documents are provided to us, the original documents will not be required.
  Note: You can only claim for the illness listed in your own contract. If abroad, provide all medical documentation in English.

Section 1. Particulars of Insured Life

Surname

Full First Name(s)

ID Number

Date of Birth (Y Y Y Y M M D D) Gender (F M) Title

Passport No. Date of Expiry (Y Y Y Y M M D D)

Country of Issue

Maiden Name

Telephone Number

Cellphone Number

Email Address

Residential address

Suite/ unit number Complex Name

Street Number Street Name

Suburb City

Region Postal Code

Section 2. Nature of Claim

1. Stipulate the illness you are claiming for.

2. Describe the symptoms you ae experiencing and state the date the symptoms began

3. Details of Doctors, Specialists and Consultations you have had regarding the condition you are claiming for.

Name and Surname	Type of Specialist	Telephone	First Consultation

4. If this is NOT your Family Doctor, state the initials, surname, telephone number and address of this Doctor who referred you to the Specialist(s) mentioned above.

Telephone Number

Section 3. Medical History

State the initials, surname, address, and telephone number of your:

Present Family Doctor

Telephone Number

Previous Family Doctor

Telephone Number

Since when have you been consulting your present Family Doctor? Y Y Y Y M M D D

Provide the following information with regards to all other Doctors or Specialists you have consulted regarding the condition that gave rise to this claim.

Name of Hospital	Reason for Hospitalisation	Patient No.	Admission Date	Discharge Date

Details of Doctors, Specialists and Consultations you have had regarding the condition you are claiming for.

Name and Surname	Type of Specialist	Address	Telephone	First Consultation

Medical Aid Details

Name of the Fund

Membership Number

Other Information

If the illness or injury occurred in a country outside South Africa, please provide the following information:

Country visited

Reason for visit

Date of Arrival Y Y Y M M D D Date of Return Y Y Y Y M M D D

Date of Accident Y Y Y M M D D

Place of accident

The disability was caused by ☐ Motor vehicle accident ☐ Accident at home ☐ Accident at work

☐ Shooting accident ☐ Other Specify

Give a brief description of how the accident happened.

If there was an investigation into the cause of the injury or illness, provide the following:

Name of Police Station

Case Number

Initials and Surname of Investigating Officer

Contact details: Telephone Fax

Findings of the investigation (provide copy of the SAPS report/Report of injury sustained at work/Court report.

Did you suffer any physical loss? Yes ☐ No ☐

If "Yes, describe the nature of the loss you suffered.

If the loss did not occur on the date of the accident, please state the date on which the loss took place.

Y	Y	Y	Y	M	M	D	D

Occupational History

Provide a detailed statement of your career, including your present or last occupation. The exact date (at least month and year) of the commencement and termination of your services are required.

Employer	Address	Telephone	Commencement	Termination	Type of Work

What was the last date on which you were actively able to do your work?

Y	Y	Y	Y	M	M	D	D

(*Not necessarily the date of termination of service*)

Date of official discharge

Y	Y	Y	Y	M	M	D	D

Describe the most important functions of your occupation(s) from which you earned an income immediately before your disability. (*From the date of official discharge)*

State the percentage of time engaged in the actions below as well as the nature of it.

Administrative duties		%	
Manual / Physical duties		%	
Supervisory duties		%	
Travelling by car, truck, etc.		%	
Walking and standing		%	
TOTAL		%	

(Note: the percentage must add up to 100%)

What is your highest educational qualification? (e.g. Std 10/Gr 12 or B. Com)

At which school or institution did you qualify?

Any other qualifications obtained?

Any skills and/or courses acquired or passed while in service?

Any study area? Business qualifications?

If you are doing any work at present, from which you are earning an income, state the type of work and the income earned.

Provide the name, address, telephone and fax number of the relevant employer.

Telephone Fax

If you are not working at present, do you intend to in the future? Yes No

If "Yes", what type of occupation do you have in mind and from which date?

Y	Y	Y	Y	M	M	D	D

If “No”, in your opinion, what prevents you from performing full-time employment?

Income particulars

What was your gross monthly income during the last 12 months before the onset of your disability? (Please indicate any overtime payment separately)

Gross R Overtime R

Provide the following information if, owing to or during your disability you are receiving, or are entitled to receive any benefit, income salary, pension or renumeration of any kind (this included money received from any employer, partner, assurance company, pension or retirement annuity fund, any government fund or from any other source – irrespective of whether a claim has been submitted):

Source of benefit/Name of company	Amount	Frequency	Inception Date	Cessation Date
	R			
	R			
	R			
	R			

What were your sources of income immediately before disability? Please tick the relevant boxes and mention the monthly amounts:

Salary from employer R Self employed R

Rental income R Pension R

Investment income R Other R

Specify other

Important!

Fill in this section only if you were self-employed. Please provide us with proof existence of your business.

What were your operating costs for the 12 months prior to disability?

What will happen to your business now that you are disabled?

If you are continuing with your business, what is your involvement (e.g. How are you involved in running the business and what is your share of the profit?

What duties did you carry out before your disability?

Have you had to appoint people to continue running your business? Yes No

If “Yes””, at what cost has this been done? (Please attach documentary evidence such as salary statements).

Self-Employment

Fill in the sections only if you were self-employed. Please provide us with proof of existence of your business.

What were your operating costs for the 12 months prior to disability?

What will happen to your business now that you are disabled?

If you are continuing with your business, what is your involvement (e.g. How are you involved in running the business and what is your share of the profit?

What duties did you carry out before your disability?

What duties do you still do after your disability?

Have you had to appoint people to continue running your business? Yes ☐ No ☐

If "Yes"", at what cost has this been done? (Please attach documentary evidence such as salary statements).

Section 4. Employer Declaration

Particulars of Employer

Full Names and Surname / Name of Institution

Name of Group Scheme (only if applicable)

Employee reference number of claimant

Postal address

Suite/ unit number ☐☐☐☐ Complex Name

Street Number ☐☐☐☐ Street Name

Suburb City

Region Postal Code

Contact details: Telephone ☐☐☐☐☐☐☐☐☐☐ Fax ☐☐☐☐☐☐☐☐☐☐

E-mail address

General Information

Date of appointment Y Y Y Y M M D D

Name of occupation

Date of appointment in this occupation Y Y Y Y M M D D

Date of official discharge Y Y Y Y M M D D

Define the essential functions of this occupation: **Please attach a non-generic job description.**

Last date on which claimant was still actively able to perform his/her job. Y Y Y Y M M D D

Date of official discharge Y Y Y Y M M D D

State the number of hours the claimant engaged in the actions below. (Note: The hours must add up to the hours the client worked). Please indicate the specific actions performed per hour.

Administrative duties		
Manual/physical duties		
Supervisory duties		
Travelling by car, truck, etc.		
Walking and standing		
Total hours		

Please state the academic qualifications of the claimant		
Gross average monthly salary before disability	Basic	R
	Overtime	R
	Other	R
Gross average monthly salary after disability	Basic	R
Gross monthly pension after disability		R

Description of employee's disability (functional impairment)

What is the cause of his/her disability?

When did you first become aware of the condition? Y Y Y Y M M D D

Was the cause an injury sustained while on duty? Yes ☐ No ☐

If "Yes", please provide us with the Injury sustained at work – report.

Current works status (Please mark the applicable option)

Still at work	☐
Working part-time	☐
On sick leave	☐
Early retirement due to ill health	☐
Working in alternative position	☐
Gross monthly pension after disability	☐ If this option is selected, please answer the following questions:

If the person was not considered for an alternative position, was it as a result of:

Was the cause an injury sustained while on duty? Yes ☐ No ☐

Was the cause an injury sustained while on duty? Yes ☐ No ☐

If the person accepted an alternative position, please answer the following questions:

Did the aspect mentioned below contribute to his/her appointment to the alternative position? Please provide reasons.

Training	Yes	☐	No	☐	
Experience	Yes	☐	No	☐	
Education	Yes	☐	No	☐	

Description of employee's disability (functional impairment)

Alternative position (continue)

Describe in full what his/her duties in the alternative position comprise and indicate exactly the nature of what he/she now does. (For example, it is not sufficient to say "He/she performs light clerical work"- please indicate the nature of the clerical work):

State the number of hours the client engaged in the actions below. (Note: The hours must add up to the hours the client worked). Please indicate the specific actions performed per hour.

Administrative duties		
Manual/physical duties		
Supervisory duties		
Travelling by car, truck, etc.		
Walking and standing		
Total hours		

Educational qualifications required for the alternative position	
Gross earnings in the alternative position	
Basic	R
Overtime	R
Other	R

Has he/she been appointed on a part-time or permanent basis? Part-time ☐ Permanent ☐

Has he/she been appointed on a part-time or permanent basis? Yes ☐ No ☐

Is this status of the alternative position higher than, equal to or lower than the position previously held?

Please provide the reasons if an alternative position was offered, but the claimant did not accept the position.

Sick Leave Records

Please provide us with a brief summary of all sick leave of longer than 2 days taken by the claimant during the past two years. Please include copies of the relevant doctor's certificates.

Illness or injury	**Name of doctor(s) consulted**	**Dates from work**		**Total days absent**
		From (dd/mm/ccyy)	**To** (dd/mm/ccyy)	

Contact person with regards to sick leave records

Contact details: Telephone Fax

E-mail address

I hereby declare that the information provided within is correct and no information was withheld.

Name and Surname of authorized official

Capacity of authorised official

Signature of authorised official		Date	Y	Y	Y	Y	M	M	D	D

Signed at

Official stamp of Institution

Section 5. Payments

Please note that the payments must be continued until a claim, if any, has been approved.

Provide us with a copy of your Bank statement (not older that three months on a Bank letterhead which indicates the account number and account holder's name.
If the claim of the Life Insured is approved, Triarc is able to make the money available by means of an Electronic Funds Transfers (EFT) to the owner of the Policy. Please provide the following details:

Account holder Name			
Bank Name			
Branch Name		Branch Code	
Account Number			
Account Type	☐ Cheque ☐ Transmission ☐ Savings		

I the undersigned, hereby declare that the above information is true and correct and confirm that Triarc will not be held liable for any loss that may arise from the use of this information.

Signature of Authorised Person		Date	Y	Y	Y	Y	M	M	D	D

Section 6. Declaration

I declare that the particulars contained in this form are true and correct. I also irrevocably authorize any Person or institution, Medical Practitioner, Medical Specialist, Hospital, Nursing Institution or Medical Authority to provide Triarc with any information that may be required regarding my health. Further, I irrevocably authorize Triarc to share t-with other insurers that information and any information contained in this proposal or any related plan or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Triarc or by the database operators.

Signature of Authorised Person		Date	Y	Y	Y	Y	M	M	D	D

The Treating Specialist

Important!

This report must be completed by a specialist and not a general practitioner.
Before you perform the examinations, please determine the client's identity with the help of a photographic proof identity.
Indicate on the report of your findings – what type of proof of identity was given.
The above-mentioned insured has required us to consider he/she qualifies for a disability claim.
The assessment of a disability claim is based on two main principals of impairment and disability. The assessment of impairment entails in practical terms, making a diagnosis and then determining on medical grounds which functions the person is still able to perform and which not. On the other hand, disability is a legal process assessing the extent of the person's impairment judges in

conjunction with his/her job description, the contract wording and personal factors such as education, experience, etc. To assist us in making this justified decision, we must be provided with a report regarding the impairment of this person. The decision regarding disability will be made by Triarc.
Please complete the report in accordance with the guidelines set out in the "Guidelines: Medical report on functional impairment" underneath after you have examined the person.
The insured is responsible for the costs relating to this consultation and medical report.
Guidelines: Medical Report on Functional impairment.
Please use the following only as a guideline to compile your report.

- Diagnosis: (DSM IV for psychiatric conditions)
- Date: of the onset and course of the disease
- Severity: Perpetual factors, secondary gain
- Current clinical findings: Describe in detail
- Treatment:
  - Treatment modalities
  - Duration and treatment
  - Rehabilitation
  - Types of medication and dosage
  - Therapeutic procedures
  - Hospitalisation
- Response to treatment
- Complications that are permanent
- Special investigations: e.g. ECG, X-Rays, Scans
- Prognosis with optimal treatment
- Influence on lifestyle, activities of daily living and working capability
- Special requirements:
- Cardiovascular: NYHA-Classification, exercise capability, stress-ECG, ejection fraction, other
- Respiratory: Dyspnoea-grading (ATS), exercise capacity (METS or VO2) max), vitalogram per- and post- inhalation (3 attempts), chest X-Ray, single-breath diffusion test (DCO) in cases of interstitial lung disease.
- Orthopeadic: X-Ray and stress views, MRI or CAT scans, other (e.g. conduction tests)
- Psychiatric: Social functioning, concentration, psychometric tests in cases of cognitive impairment

Section 7. Processing of Personal Information on 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.

Name and Surname									
Signed at									
Signature		Date	Y	Y	Y	Y	M	M	D	D

Annexure A – Supporting Documents

The following supporting documentation must be submitted:

Policyholder	
Declaration by Employer – Form (if you are not self-employed)	
If you are self-employed, please provide us with proof of the existence of your business, for example audited Financial Statements or tax Assessments and Statements, Receipts or Affidavits from persons with whom business has been conducted	
Certified Copy (by a Commissioner of Oaths) of your Identity document or back and front copies of the Identity card	
Copies of all medical reports including those by which you were medically boarded	
SAPS report or reports of injury sustained at work if a claim was caused by an accident on duty, as well as the result of the investigation if already finalized	
A report by the treating Specialist (attached)	
Copies of payslips for the last 3 months	
Copies of your sick leave certificates	

Directors: A.Dique - G.J.Nepgen - D.Acres

TRIARC is an authorised financial services provider FSP 45009 underwritten by Guardrisk Life Limited a licensed life insurer and an authorised financial services provider FSP 76