

# Disability claim - employer declaration

## Employer 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:

- Copy of payslip as at date of disability
- A copy of member's ID/passport
- Copy of the claimant's employer issued job description
- Copy of the claimant's leave records for the 2 year period preceding their date of disability

We will also require the Disability Claim - Employee Declaration, Disability Claim - Confidential Medical Report and copies of all relevant clinical investigation findings in order to assess this claim.

Completed form together with supporting documents to be faxed to +264 61 234 851 or emailed to [ebnamdisability@momentum.com.na](mailto:ebnamdisability@momentum.com.na) or posted to PO Box 3785, Windhoek 9000, attention Momentum Employee Benefits disability claims.

### 1. Scheme details

Scheme name:

Employer name:

### 2. Member details

Title  Initials

First name/s

Surname

Date of birth   -   -

Namibian ID  Yes  No  ID/Passport No.

Passport country of origin

Date joined company   -   -

Date joined scheme   -   -

Company/employee No.

### 3. Employer details

Contact person at the company

Designation

Tel No.  Fax

Email

Address (Head office)

Postal code:

Address (office/branch where member worked)

Postal code:

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#### 4. Reason for notification

Reason for notification (Please tick  the appropriate criteria)

Absenteeism

- Absent from work for 10 consecutive days
- Absent from work for five days (consecutive or non-consecutive) in any 30-day period, without medical evidence or notifying the company
- Consistently absent on Fridays and/or Mondays, or both
- Consistently absent for one or more days per month
- Total absence of 20 days or more in any one year

Productivity Loss

- Marked loss of productivity due to physical and/or psychological conditions

Injury

- Injury on duty requiring treatment, hospitalisation or absence from work
- Injury off-site requiring treatment, hospitalisation or absence from work

Impairment

- Employee complaint of disability/impairment/difficulty in meeting work requirements
- Employee declared disabled / unfit for work by treating doctor
- Employee has medical condition requiring treatment, hospitalisation or absence from work

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#### 5. Details of occupation (Note - a job description must be attached)

a. Occupation/Job title

Occupation/Job title \_\_\_\_\_

Details of duties. List FIVE main performance areas with a brief description of each:

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_

Is the member responsible for the supervision of any staff?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If Yes, number of staff supervised

Normal working hours of job per week:  hours

Normal working days of job per week \_\_\_\_\_

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**b. Work environment**

What percentage of the working day does the member work?

Indoors  %

Outdoors  %

At heights  %

At depths  %

Temperature range in place of work  to  Degrees centigrade

Decibel range in place of work  to  decibels

Is the member exposed to any dust while working?  Yes   No

If Yes, please state the type of dust the member is exposed to

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Is the member exposed to any fumes while working?  Yes   No

If Yes, please list all fumes the member is exposed to

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Please give details of any known safety hazards in the member's job

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**c. Physical demands**

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

Lifting weights  Yes  No  Range of weights lifted  to  kg

Carrying weights  Yes  No  Range of weights carried  to  kg

Pushing weights  Yes  No  Range of weights pushed  to  kg

Pulling weights  Yes  No  Range of weights pulled  to  kg

Does the member's job involve any climbing?  Yes   No

If Yes, indicate what type of climbing (eg stairs, ladders, scaffolding) and frequency

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Please indicate how much time is spent on the following activities during each working day. Tick the relevant column and indicate duration

	Never	Sometimes	Often	Always	Hours per day
Sitting					
Kneeling					
Standing					
Bending					
Walking on even terrain					
Walking on uneven terrain					
Use of both hands					
Use of fine coordination					
Engaging in physical labour					
Reaching above shoulder height					
Reaching below shoulder height					
Working in cramped conditions					

Where the member's job involves manual/physical labour, please specify the tasks involved

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Please list items used in the course of the member's work

Equipment used \_\_\_\_\_

Tools used \_\_\_\_\_

Materials used \_\_\_\_\_

Machinery used \_\_\_\_\_

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**d. Driving**

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

Licence code/s required \_\_\_\_\_

Type of vehicle/s driven \_\_\_\_\_

Average distance driven

Per day  km

Per week  km

Per month  km

**e. Flying**

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

Type of aeroplane flown \_\_\_\_\_

Average distance flown per week  km

Average number of hours flown per week  hours

**f. Cognitive demands**

Please indicate how much of the member's job requires the following abilities during each working day. Tick the relevant column and indicate duration

	Never	Sometimes	Often	Continuously	Hours per day
Concentration					
Memory					
Planning					
Problem solving					
Decision making					
Administration / Clerical tasks					
Calculations / Working with figures					

**g. Communication demands**

Please indicate how much of the member's job requires the following abilities during each working day. Tick the relevant column.

	Never	Sometimes	Often	Continuously	Hours per day
One-to-one communication					
One-to-group communication					
Verbal communication					
Written communication					
Communication with colleagues					
Communication with clients					

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## 6. Details of employment history

Please indicate the member's full employment history at current employer, from the most recent to the earliest position.

	Most recent	Previous	Earlier Position
Date started			
Job title			
Broad description of work done			
Date ceased			
Salary at date of cessation			
Reason for cessation			

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## 7. Salary history

Please provide full details of the member's salary history over the last two years. If the member has worked for the employer for less than two years, please indicate the salary history from the date of appointment.

Date				
Amount of increase				
New salary				
Frequency paid (weekly / monthly / annually)				
Reason for change (annual increase, annual bonus, promotion)				
Estimated amount of additional earnings through overtime, commissions etc				
Date ceased				

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## 8. Other compensation

Please list any other sources of compensation the member may receive as a result of disability

Current or expected future income			
Source of income eg employer, self employment, other insurer, UIF, workmans compensation etc			
Amount of income	R	R	R
How payable (monthly, lump sum)			
Date of commencement of payment			
Policy number/s (if applicable)			

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## 9. Details of disablement

When did the illness first become evident or the injury occur?

D	D	-	M	M	-	Y	Y	Y	Y
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Last day actively able to perform normal full time duties of own occupation?

D	D	-	M	M	-	Y	Y	Y	Y
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Last day physically at work?

D	D	-	M	M	-	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

Was the member in active full-time and permanent employment on the last day of work?

Yes			No		
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If No, please give details

Was the member placed into another position prior to claiming for disability?

Yes			No		
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If Yes, please give details including job title and duties of the position, date started in this position, date ceased in this position and reason for member being placed in this position

Was the member's normal occupation changed in any way prior to claiming for disability?

Yes			No		
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If Yes, please give a detailed description of changes made, dates on which these changes were made and reasons for changes being made

Details of any attempts and efforts made to adapt the member's work environment to accommodate their impairment/s

Which aspects of the member's most recent job is he/she unable to do and why?

If the member has been subject to any particular pressures, either at work or outside of work, please comment on these

Can the member be placed in another/alternative occupation?

Yes			No		
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If No, please state why not

If Yes, please give details of possible alternatives

Has the impairment/disability affected the member's salary?

Yes			No		
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When did he/she last receive a full salary

D	D	-	M	M	-	Y	Y	Y	Y
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Has the member's salary been reduced?

Yes			No		
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If Yes, from what date

D	D	-	M	M	-	Y	Y	Y	Y
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If Yes, please indicate new, reduced, monthly salary

R									
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Date on which member returned to work (if they have already returned after disability)

D	D	-	M	M	-	Y	Y	Y	Y
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Date on which member is expected to return to work (if they have not yet returned to work)

D	D	-	M	M	-	Y	Y	Y	Y
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## 10. Employer banking details

Name of account holder	<input type="text"/>		
Name of bank	<input type="text"/>		
Account number:	<input type="text"/>	Branch no.:	<input type="text"/>
Account type:	<input type="checkbox"/> Current/cheque	<input type="checkbox"/> savings	<input type="checkbox"/> transmission

## 11. Supporting documents required

I have included the following

Copy of payslip as at date of disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Copy of members ID / Passport	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Copy of job description	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Copy of leave records	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## 12. Declaration by employer

I hereby declare that all particulars furnished in this form and accompanying documents are true and correct and that no material information has been withheld or omitted. I authorise Momentum to disclose this information to any other party whose opinion is required for the assessment of the claim.

Name of person completing this form	<input type="text"/>
Designation	<input type="text"/>
Telephone - work	<input type="text"/>
Email	<input type="text"/>

**Signature of 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"/>
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**Date**

### Options to sign the form:

1. Print out the form, sign and scan it and send it back via email to [ebnamdisability@momentum.com.na](mailto:ebnamdisability@momentum.com.na), fax it to Fax +26 (4)61 234 851 or posted to PO Box 3785, Windhoek 9000, attention Momentum Employee Benefits disability claims.
2. Place your scanned signature in the signature block.
  - Store your scanned signature in a safe place on your computer.
  - Select the 'comments' tab from your menu in Adobe.
  - Select the 'add stamp' icon.
  - Select custom stamps.
  - Create custom stamps.
  - You can now browse and upload your signature to save it as a custom stamp under 'sign here' in Adobe.
  - You can now go back to your 'stamps' icon and select 'sign here' and select your saved signature.
  - Place it in the document and save the document.

When you want to print the form to complete by hand you can turn off the field highlights by selecting the "highlight existing fields" on the top right hand corner of your screen.

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**Windhoek:** MMI House 4th floor cnr Frans Indongo & Werner List Street P.O.Box 3785 Windhoek Namibia  
**Cape Town:** Parc du Cap 4 Mispel Road Bellville 7530 PO Box 2212 Bellville 7535 South Africa  
**Pretoria:** 268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa  
[www.momentum.co.za](http://www.momentum.co.za)

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