corporate

# Spouse disability benefit - application form Policyholder, main member and spouse 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.

We will also require all documents listed under Section 8 as well as the Spouse Disability Claim Confidential Medical Report with copies of all relevant clinical investigation findings in order to assess this claim.

Completed form together with supporting documents to be faxed to 021 917 3711 or emailed to wcc@momentum.co.za or posted to PO Box 2212, Bellville, 7535, attention Momentum Group Insurance disability claims.

1. Scheme details.		
Scheme name		
Employer name		
2. Employer details.		
Contact person at company		
Designation		
Telephone	Fax	
Email		
Company address (head office)		
		Postal code
Company address (office/branch)		
where main member works		Postal code
3. Main member details.		
Title	Initials	
First name/s		
Surname		
Date of birth	D D - M M - Y Y Y	
RSAID	Yes No ID / Passport no	
Passport country of origin		
Marital Status	Married Single Divorced Widowed	Permanent Life Partner
Postal address		
		Postal code
Contact number		
Email		
Income tax office	Income tax number	
Date employment commenced	D D - M M - Y Y Y Y	
Company/employee No		

4. Applicant (Spouse) det	ails.	
Title	Initials	
First name/s		
Surname		
Date of birth	D D - M M - Y Y Y	
RSA ID	Yes No ID / Passport no	
Passport country of origin		
Postal address		
		Postal code
Contact number		
Email		
Relationship to main member	Spouse Permanent Life Partner	
5. Occupational informati	on (to be completed by the applicant).	
Are you currently employed?	Yes No If No, please skip to section 6.	
Date when you started working for your c	urrent employer	D - M M - Y Y Y
Date when you started in your current occ	cupation/position	D - M M - Y Y Y
Job title		
Details of duties. List five key activities an	d give a brief description of each.	
1.		
2.		
3.		
4.		
5.		
Date last able to actively perform your no		
When do you expect to be able to take up On a part-time basis?	any occupation in the future?  On a full-time basis?  On a full-time basis?	M Y Y Y
What is your current employment status?	- On a full-time pasis!	
	part-time On sick leave On unpaid leave	
Laid off or retrenched Dism	issed Other	
If Other, please specify.		
Have you been able to perform part of you	ur job, or another job, since your impairment?	Yes No
What duties can you no longer do?		
_		
What duties can you still do?		

	duties changed														
		Details of the adap	ted duties			Date	dutie	s cha	nged			S	alary	•	
Apart from you	r present occur	pation, please supply a bri	ef employment hist	ory inclu	ling previous po	eitione he	ıld at d	rurran	t and	1 previo	uic 4	omr	love	re	
Date started	Date ended	Company	Position held		Type of work	ositions ne				Reaso					
	24.0 0.1404	Jon.,pa.i.y			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		of lea						9		
Details of your	auglifications t	training and experience													
Details of your	qualifications,		ear achieved	Standa	rd/Qualification										
Highest level	of schooling		odi domovou	Otarida	u, Qualification										
_		C, diplomas, etc.)													
	,	,													
Academic qua	alifications (e.g.	degrees, etc.)													
Other training	(e.g. certificate	es,in-house training, driver	's licences & codes	s)											
What alternativ	e occupation/s	do you consider yourself	qualified for?												
6. Medic	cal informa	ation (to be comple	eted by the ap	plicant)											
			eted by the ap	plicant)											
6. Medic			eted by the app	plicant)					_	noticed			V	V	
			eted by the app	plicant)				D D	-	M M	-	Y	_	Y	Y
			eted by the app	plicant)	•			D D	) -	M M	-	Υ	Υ	Y	Υ
			eted by the app	olicant)	•			<ul><li>D</li><li>D</li><li>D</li><li>D</li></ul>	) - ) -	M M M M	-	Y	Y	Υ	Y
			eted by the app	plicant)				D D D D D D	) - ) - ) -	M M M M M M	-	Y	Y	Y	Υ
List of diagnose	es/symptoms/c	omplaints.				no longer		D D D D D D	-	M M M M M M M M M M M	-	Y	Y	Υ	Y
List of diagnose	es/symptoms/c					no longer		D D D D D D	-	M M M M M M M M M M M	-	Y	Y	Y	Y
List of diagnose	es/symptoms/c	omplaints.				no longer		D D D D D D	-	M M M M M M M M M M M	-	Y	Y	Y	Y
List of diagnose	es/symptoms/c	omplaints.				no longer		D D D D D D	-	M M M M M M M M M M M	-	Y	Y	Y	Y
List of diagnose	es/symptoms/c	omplaints.				no longer		D D D D D D	-	M M M M M M M M M M M	-	Y	Y	Y	Y
List of diagnose	es/symptoms/c	omplaints.				no longer		D D D D D D	-	M M M M M M M M M M M	-	Y	Y	Y	Y
List of diagnose  How does the i	es/symptoms/c	omplaints.	al every day tasks a	at home?	What can you	no longer		D D D D D D	-	M M M M M M M M M M M	- - - till d	Y	Y	Y	Y
List of diagnose  How does the i	es/symptoms/compairment affer elast 5 years,	omplaints.	al every day tasks a	at home?	What can you	no longer		D D D D D D	-	M M M M M M M M M M M M	- - - till d	Y	Y	Y	Y
How does the in	es/symptoms/compairment affer elast 5 years,	omplaints.	al every day tasks a	at home?	What can you	no longer		D D D D D D	-	M M M M M M M M M M M M	- - - till d	Y	Y	Y	Y
How does the in	es/symptoms/compairment affer elast 5 years,	omplaints.	al every day tasks a	at home?	What can you	no longer		D D D D D D	-	M M M M M M M M M M M M	- - - till d	Y	Y	Y	Y
How does the in	es/symptoms/compairment affer elast 5 years, provide details.	omplaints.	al every day tasks a	at home?	What can you	no longer		D D D D D D	-	M M M M M M M M M M M M	- - - till d	Y	Y	Y	Y
How does the in	es/symptoms/compairment affer elast 5 years, provide details.	omplaints.	al every day tasks a	at home?	What can you	no longer	do an	D D D D D D D D D D D D D D D D D D D		M M M M M M M M M M M M	till d	Y Y Y Y Y	Y	Y	Y
How does the in the lif Yes, please pure potentials of any high potentials.	es/symptoms/compairment affer elast 5 years, provide details.	omplaints.  ect you in doing your norm suffered from any serious within the last 2 years.	al every day tasks a	at home?	What can you	no longer	do an	D D D D D D D D D D D D D D D D D D D		M M M M M M M M M M M M M M M M M M M	till d	Y Y Y Y Y	Y	Y	Y
How does the in the lif Yes, please pure potentials of any high potentials.	es/symptoms/compairment affer elast 5 years, provide details.	omplaints.  ect you in doing your norm suffered from any serious within the last 2 years.	al every day tasks a	at home?	What can you	no longer	do an	D D D D D D D D D D D D D D D D D D D		M M M M M M M M M M M M M M M M M M M	till d	Y Y Y Y Y	Y	Y	Y
How does the in the lif Yes, please pure potentials of any high potentials.	es/symptoms/compairment affer elast 5 years, provide details.	omplaints.  ect you in doing your norm suffered from any serious within the last 2 years.	al every day tasks a	at home?	What can you	no longer	do an	D D D D D D D D D D D D D D D D D D D		M M M M M M M M M M M M M M M M M M M	till d	Y Y Y Y Y	Y	Y	Y

Current treatme	nt. Please list all m	edication you are	on, provide na	ame and dosage				
	names of all doctor er and email addre				in connection with your in our doctor.	npairment/disabi	lity. Please pr	ovide us with the
Date from		•						
Date to								
Hospital / Docto	r							
Speciality								
Tel no.								
Email address								
Patient Number								
Please give the	name address en	nail address and t	el number of v	our regular fami	y doctor/general practition	ner		
Name	namo, addroco, on	nan adarooo ana t	or riambor or y	our rogular larrii	y doctor, gorrorar practition			
Address							Г	
							Postal code	
Tel No.						Fax		
Email								
Date that you fin	st visited your curre	ent general practit	tioner			D D	- M M -	YYYY
-	-	oni gonorai praom						
	1 4 14 - 4! 0					D D	- M M -	YYYY
vvnen was your	last consultation?							
f you have char	ged general practi	tioners in the last	two years, ple	ease give details	of all previous attending g	general practition	ner/s.	
f you have char	ged general practi		two years, ple	ase give details		general practition		
f you have char	ged general practi	Doctor's name	two years, ple	ase give details	of all previous attending g	general practition	ner/s.	
If you have char	ged general practi		two years, ple	ase give details		general practition		
lf you have char	ged general practi		two years, ple	ase give details		general practition		
f you have char	ged general practi	Doctor's name				general practition		
From Indicate your ab	ged general practi Dates To	Doctor's name		Advanced		general practition		Not able
From Indicate your ab Basic Control bowels	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car	Hospital/Practice name		Tel no	Not able
From Indicate your ab Basic Control bowels Control bladder	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care:	Hospital/Practice name		Tel no	Not able
From Indicate your ab Basic Control bowels Control bladder Grooming	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manag	Hospital/Practice name  prepares and takes corre	ct medication	Tel no	Not able
From Indicate your ab Basic Control bowels Control bladder Grooming Toileting	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manag	Hospital/Practice name  prepares and takes corregment re activities: use of phone	ct medication	Tel no	Not able
From Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manag Communication Shopping: lifti	Hospital/Practice name  prepares and takes corregment re activities: use of phone ng or carrying groceries	ct medication	Tel no	Not able
From Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manag Communicativ Shopping: lifti Food prepera	Hospital/Practice name  prepares and takes corregment re activities: use of phone ng or carrying groceries	ct medication	Tel no	Not able
From Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from Indoor mobility	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manaç Communicativ Shopping: lifti Food prepera Housework	prepares and takes corregment re activities: use of phone or carrying groceries	ect medication e, writing letters	Tel no	Not able
From Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manage Communicativ Shopping: lifti Food prepera Housework Community at	Hospital/Practice name  prepares and takes corregment re activities: use of phone ng or carrying groceries	ect medication e, writing letters	Tel no	Not able
From Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from Indoor mobility Dressing	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manage Communication Shopping: lifti Food preperat Housework Community and device.	prepares and takes corregment ve activities: use of phone ng or carrying groceries tion mbulation with or without a	ect medication e, writing letters assistive	Tel no	Not able
From Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from Indoor mobility	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manage Communicativ Shopping: lifti Food prepera Housework Community and device. Moderate acticleaner, bowli	prepares and takes corregment ve activities: use of phone ng or carrying groceries tion mbulation with or without a vities: moving table, pushing, golf	assistive	Tel no	Not able
From Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from Indoor mobility Dressing	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manage Communicativ Shopping: lifti Food prepera Housework Community and device. Moderate acticleaner, bowli	prepares and takes corregment ve activities: use of phone ng or carrying groceries tion mbulation with or without a	assistive	Tel no	Not able
From  Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from Indoor mobility Dressing Stairs	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manage Communicativ Shopping: lifti Food prepera Housework Community and device. Moderate acticleaner, bowli	prepares and takes corregment ve activities: use of phone ng or carrying groceries tion mbulation with or without a vities: moving table, pushing, golf	assistive	Tel no	Not able
From  Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from Indoor mobility Dressing Stairs Bathing	ged general practi Dates  To  Ility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manage Communicativ Shopping: lifti Food prepera Housework Community and device. Moderate acticleaner, bowli	prepares and takes corregment ve activities: use of phone ng or carrying groceries tion mbulation with or without a vities: moving table, pushing, golf	assistive	Tel no	Not able
From  Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from Indoor mobility Dressing Stairs Bathing	ged general practi Dates To lility to perform Act	Doctor's name	ing.	Advanced Driving a car Medical care: Money manage Communicativ Shopping: lifti Food prepera Housework Community and device. Moderate acticleaner, bowli	prepares and takes corregment ve activities: use of phone ng or carrying groceries tion mbulation with or without a vities: moving table, pushing, golf	assistive	Tel no	Not able
From Indicate your ab Basic Control bladder Grooming Toileting Feeding Transfers from Indoor mobility Dressing Stairs Bathing	ged general practi Dates To Sility to perform Act Chair to bed	Doctor's name	ing.	Advanced Driving a car Medical care: Money manage Communicativ Shopping: lifti Food prepera Housework Community and device. Moderate acticleaner, bowli Vigorous activ	prepares and takes corregment ve activities: use of phone ng or carrying groceries tion mbulation with or without a vities: moving table, pushing, golf	assistive	Tel no	Not able
From  Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from Indoor mobility Dressing Stairs Bathing  7. Bankii To whom must be	ged general practi Dates  To  Ility to perform Act  chair to bed  ng details.  enefit be paid?	Doctor's name	ing.  Not able	Advanced Driving a car Medical care: Money manage Communicativ Shopping: lifti Food prepera Housework Community and device. Moderate acticleaner, bowli Vigorous activ	prepares and takes corregment ve activities: use of phone ng or carrying groceries tion mbulation with or without a vities: moving table, pushing, golf vities: running, heavy lifting	assistive	Tel no	Not able
From Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from Indoor mobility Dressing Stairs Bathing To whom must be Name of accounter	ged general practi Dates  To  Ility to perform Act  chair to bed  ng details.  enefit be paid?	Doctor's name	ing.  Not able	Advanced Driving a car Medical care: Money manage Communicativ Shopping: lifti Food prepera Housework Community and device. Moderate acticleaner, bowli Vigorous activ	prepares and takes corregment ve activities: use of phone ng or carrying groceries tion mbulation with or without a vities: moving table, pushing, golf vities: running, heavy lifting	assistive	Tel no	Not able
From  Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from Indoor mobility Dressing Stairs Bathing To whom must be Name of accounter Name of bank	nged general practi Dates  To  lity to perform Act  chair to bed  ng details. enefit be paid? t holder	Doctor's name	ing.  Not able	Advanced Driving a car Medical care: Money manage Communicativ Shopping: lifti Food prepera Housework Community and device. Moderate acticleaner, bowli Vigorous activ	prepares and takes corregment ve activities: use of phone ng or carrying groceries tion mbulation with or without a vities: moving table, pushing, golf vities: running, heavy lifting	assistive ing vaccum g, sports	Tel no	Not able
f you have char  From  Indicate your ab Basic Control bowels Control bladder Grooming Toileting Feeding Transfers from Indoor mobility Dressing Stairs Bathing  7. Bankii To whom must be	nged general practi Dates  To  lity to perform Act  chair to bed  ng details. enefit be paid? t holder	Doctor's name	ing.  Not able	Advanced Driving a car Medical care: Money manage Communicativ Shopping: lifti Food prepera Housework Community and device. Moderate acticleaner, bowli Vigorous activ	prepares and takes corregment ve activities: use of phone ng or carrying groceries tion mbulation with or without a vities: moving table, pushing, golf vities: running, heavy lifting	assistive	Tel no	Not able

#### 8. Supporting documents required. Yes No I have attached a copy of the main member's payslip I have attached a copy of my job description (if employed) No Yes I have attached a copy of my leave records for the past 2 years from my employer. Yes No I have attached a copy of my marriage certificate (if a registered marriage) Yes No I have attached the relevant affidavit found at the end of this form which has been completed by the main member under this policy, who is my spouse, and signed by a Commissioner of Oaths (if a customary union, or a marriage concluded under the Yes No tenets of any other religion, or a Permanent Life Partner) Declaration by main member's employer. 9.

I declare that all particulars furnished in sections 1 to 4 of this form are true and correct and that no material information has been withheld.

I give Momentum Corporate permission to share this information with any other party who requires this information for the purpose of assisting Momentum

Corporate in the assessment and manage	ement of this claim.
I declare that I have the necessary author	ity to complete and sign this form on behalf of the employer
Name of person completing this form	
Designation	
Contact number	
Email	
Signature of Employer	Date DD - MM - YYYY

#### 10. Consent.

First name's Sumane RSA ID Vas No ID / Passport no    RSA ID   Vas No   ID / Passport no   RSA ID   Vas   No   ID / Passport no   (full name of applicant declare that all the information given on this claim form is true and correct, and that no material information has been withheld. I understand that any incorrect and/or misrepresentation of information could be used as a reason for the claim not being approved.  Consent to collect and share personal, medical and health information Momentum Corporate may process all information of the properties and provides and provide	10a. Applicant's (i.e. Spouse's	) declaration and consent to collect	and snare personal and nea	ith information
Passport country of origin  Declaration  I	First name/s			
Passport country of origin  Declaration  I (full name of applican declare that all the information given on this claim form is true and correct, and that no material information has been withheld. Lunderstand that any incorrect and/or misrepresentation of information could be used as a reason for the claim not being approved.  Consent to collect and share personal, medical and health information.  Momentum Corporate may process all information provided on this form. Information will be processed in accordance with the Protection of Personal Information ALD 2013 and Momentum Corporate's full information and 2013 and Momentum Corporate's full information and 2013 and Momentum Corporate's full privacy policy can be found on www momentum.co.za.  Consent and give permission for "  - any health pracilitioner (e.g. doctor, psychiatrist etc.), allied health practitioner (e.g. docupational therapist, psychologist etc.), medical institution, medical aid, employer, insurance company, health risk management service provider appointed by the policyholder or any other person or institute that has information about my health, employment related activities and personal information, to provide such information to Momentum Corporate any third party norminated by Momentum Corporate who requires this information for the purposes of assessment of my comment and personal information contained in medical reports or otherwise which they have obtained in the ocurse of the assessment of my calma, with a health practicioner, alided health prac	Surname			
Declaration  I declare that all the information given on this claim form is true and correct, and that no material information has been withheld. I understand that any incorrect and/or misrepresentation of information could be used as a reason for the claim not being approved.  Consent to collect and share personal, medical and health information Momentum Corporate may processe all information provided on this form. Information will be processed in accordance with the Protection of Personal Momentum Corporate's full privacy policy can be found on www.momentum.co.za.  Lonasard and give paramission for:  any health practitioner (e.g., decides, speythaltrist etc.), allied health practitioner (e.g., decides, appricialtrist in the protection of the privacy policy can be found on www.momentum.co.za.  Lonasard and give paramission for:  any health practitioner (e.g., decides, appricialtrist in the protection of the privacy policy can be found on www.momentum.co.za.  Lonasard and give paramission for:  any health practitioner (e.g., decides, appricialtrist in the protection of the privacy policy can be found on www.momentum.co.za.  Lonasard and give paramission for:  any health practitioner (e.g., decides, appricialtrist in the protection of the privacy policy can be found on www.momentum.co.za.  any third party nominated by Momentum.Corporate who requires this information for the purposes of assessing and managing my claim.  Momentum Corporate in the assessment of my claim, with a health practitioner, alled health practitioner, led health practitioner, elide health practitioner, health risk managing my claim to the proposed of the benefit practition of assessing the payment of a benefit under a level provise or appropriated by the policyholder.  Any chart proposed to share any medical, occupational and personal information contained in medical reports or otherwise, which they have again that insurer, and with Astule for stallsistical purposes and for the managinem of over insurance and fraued in the insurance inclusit	RSA ID	Yes No	ID / Passport no	
declare that all the information given on this claim form is true and correct, and that no material information has been withheld. I understand that any incorrect and/or misrepresentation of information could be used as a reason for the claim not being approved.  Consent to collect and share personal, medical and health information Momentum Corporates may process all information provided on this form, information Act, 2013 and Momentum Corporate's strict policies on protecting the confidentiality of my personal information. Momentum Corporate's strict policies on protecting the confidentiality of my personal information. Momentum Corporate's strict policies on protecting the confidentiality of my personal information. Momentum Corporate's third privacy policy can be found on www.momentum Corporate's third privacy policy can be found on www.momentum Corporate's third privacy policy can be found on www.momentum Corporate's third privacy policy can be found on www.momentum Corporate's third privacy policy can be found on which may be also an expension of the protection of the pr	Passport country of origin			
declare that all the information given on this claim form is true and correct, and that no material information has been withheld. I understand that any incorrect and/or misrepresentation of information could be used as a reason for the claim not being approved.  Consent to collect and share personal, medical and health information  Momentum Corporate may process all information provided on this form, Information will be processed in accordance with the Protection of Personal Information AC 2013 and Momentum Corporate's total privacy policy can be found on www.momentum.co.pa.  Consent and give permission for:  - any health practitioner (e.g., dector, psychiatrist etc.), allied health practitioner (e.g., occupational therapist, psychologist etc.), medical institution, medical aid, employer, insurance company, health insight his kmanagement service provider appointed by the policyholder or any other person or institution that has information for the purposes of assessing and managiner any third party nominated by Momentum Corporate who requires this information for the purposes of assessing and managiner service provider appointed by the policyholder, or any third party nominated by distinct the next proposed and personal information contained in medical reports or otherwise which they have obtained in the ocurse of the assessment of adminishment processing and personal information contained in medical reports or otherwise which they have obtained in the ocurse of the assessment of adminishment proposed by the policyholder.  Momentum Corporate to share any medical, occupational and personal information contained in medical reports or otherwise, which they have obtained in the ocurse of the assessment of my claim, with other insurers for the purpose of assessment of any related claim that ingith have aga of the proposed to share any medical, occupational and personal and special personal information, reporting my claim to the policyholder or its duly appointed intermediany my claim to the policyholder or its duly	Declaration			
Consent to collect and share personal, medical and health information Momentum Corporate may process all information provided on this form. Information will be processed in accordance with the Protection of Personal Information Act, 2013 and Momentum Corporate's strict policies on protecting the contidentiality of my personal information. Momentum Corporate's bull privacy policy can be found on wavenimentum. Corporate's bull privacy policy can be found on wavenimentum. Corporate's bull privacy policy can be found on wavenimentum. Corporate's bull privacy policy can be found on wavenimentum. Corporate's bull privacy policy can be found on wavenimentum. Corporate any high practitioner (e.g., accupational therapist, psychologist etc.), medical institution, medical aid, employer, insurance company, health risk management service provider appointed by the policyholder or any other person or institution, medical aid, employer, insurance company, health risk management service provider appointed by the policyholder or any other person or institution; and the provider of the propose of assessing and managing my claim. Administration of the propose of assessing and managing my claim. Administration of the propose of assessing and managing my claim. When the propose of assessing the payment of a benefit under a risk policy where I am the policyholder.  Momentum Corporate to the assessment of my claim, with a health practitioner, benefit in the risk management of any claim or for assessing the payment of a benefit under a risk policy where I am the policyholder.  Momentum Corporate to share any medical, occupational and personal information contained in medical reports or otherwise, which they have a path insurer, and with Astute for statistical purposes and for the management of ower insurance and fraud in the insurance for the process of the assessment of my claim, with other insurers for the purpose of assessment of any related claim that in the policyholder or any with a path of the path of the path of the path of the	1			(full name of applicant),
Momentum Corporate may process all information provided on this form. Information will be processed in accordance with the Protection of Personal Information Act, 2013 and Momentum Corporate's stitic policies on protecting the confidentiality of my personal information. Momentum Corporate's full privacy policy can be found on www.momentum.co.za.  Lorenset and give permission for:  ** any health practitioner (e.g., doctor, psychiatrist etc.), allied health practitioner (e.g., occupational therapist, psychologist etc.), medical institution, medical aid, employer, instructions and personal information. The provides are any other person or institution and the provide activity of the policyholder or any other person or institution that has information about my health, employment related activities and personal information, to provide such information to Momentum Corporate who the provide appointed by the policyholder or any other personal information to provide such information to the provide any provide activity of the provide activity of the provide activity of the provide any provide activity of the provide activity of				understand that any
<ul> <li>any health practitioner (e.g. doctor, syschlatrist etc.), allied health practitioner (e.g. occupational theraipsit, psychologist etc.), medical aid, employer, insurance company, health risk management service provider appointed by the policyholder or any other person or institution that has information about my health, employment related activities and personal information, to provide such information to Momentum Corporate any third party nominated by Momentum Corporate who requires this information for the purposes of assessing an anaging my claim.</li> <li>Momentum Corporate to share 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, with a health practitioner, alled health practitioner, feath funder a risk policy where I am the policyholder.</li> <li>Momentum Corporate to share 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, with other insurers for the purpose of assessment of any related claim that I might have again that insurer, and with Astute for statistical purposes and for the management of over insurance and fraud in the insurance industry.</li> <li>Momentum Corporate to send correspondence which may include personal and special personal information, regarding my claim to the policyholder or its duly appointed intermedial. The purpose of this correspondence is to inform them of the status and outcome of my claim.</li> <li>Momentum Corporate to provide the policyholder or its duly appointed intermedial. The purpose of this correspondence is confirm them of the status and outcome of my claim.</li> <li>Momentum Corporate to provide the policyholder or its duly appointed intermedial personal information, with the guide claims status reports unless the well contain personal information. In the status reports unless the well contained to the provide</li></ul>	Momentum Corporate may process all inf Information Act, 2013 and Momentum Co privacy policy can be found on www.mom	ormation provided on this form. Information will rporate's strict policies on protecting the confide		
Signature of Applicant  *If applicant is unable to sign the consent due to medical incapacity, please contact us so that we can further assist.  10b. Main Member's consent for Momentum to assess the Applicant's (i.e. Spouse's) eligibility for a disability benefit.  I provide consent for my spouse to submit a claim for disability benefits. I further give consent to Momentum Corporate to assess the claim and provide outcome in accordance with the policy provisions.	medical aid, employer, insurance conthat has information about my health any third party nominated by Momer  Momentum Corporate to share any robtained in the course of the assess appointed by the policyholder, or any Momentum Corporate in the assessing policyholder.  Momentum Corporate to share any robtained in the course of the assess that insurer, and with Astute for statistic Momentum Corporate to send correst or its duly appointed intermediary. The Momentum Corporate to provide the information. Momentum Corporate with Momentum Corporate to share all minder the list below):  Policyholder (including policyhome Financial Advisers and Intermed Any other person/s appointed by All of the above Momentum Corporate will share med that I will not hold Momentum Corporate will share med that I will not hold Momentum Corporate.	mpany, health risk management service provided, employment related activities and personal infutum Corporate who requires this information for medical, occupational and personal information ment of my claim, with a health practitioner, allied third party nominated by Momentum Corporatement and management of my claim or for assest medical, occupational and personal information ment of my claim, with other insurers for the pure stical purposes and for the management of overspondence which may include personal and spense purpose of this correspondence is to inform the policyholder or its duly appointed intermediary will not share any health related information (special personal and health related information (special personal and health related information in the dical and health related information in myself by me in writing	r appointed by the policyholder or any formation, to provide such information to the purposes of assessing and manage contained in medical reports or otherwised health practitioner, health risk manage who may require such information for sing the payment of a benefit under a recontained in medical reports or otherwite pose of assessment of any related claimsurance and fraud in the insurance in cicial personal information, regarding my hem of the status and outcome of my civit regular claims status reports which e status reports unless I have given expressional information) with the following the status as consented above at its sole distributed as a consented above at its sole distributed in the status and outcome of my civit regular claims status reports which e status reports unless I have given expressional information) with the following the status as consented above at its sole distributed as a consented above at its sole distributed in the information of the status and outcome of my civit regular claims status reports which expressions are status reports unless I have given expressions.	other person or institution of Momentum Corporate or ging my claim. Is each they have gement service provider the purpose of assisting isk policy where I am the see, which they have gement I might have against and ustry. It is a claim to the policyholder claim. In will contain personal press written consent. In hird parties (please select secretion. I hereby confirm secretion.
Signature of Applicant  *If applicant is unable to sign the consent due to medical incapacity, please contact us so that we can further assist.  10b. Main Member's consent for Momentum to assess the Applicant's (i.e. Spouse's) eligibility for a disability benefit.  I provide consent for my spouse to submit a claim for disability benefits. I further give consent to Momentum Corporate to assess the claim and provide outcome in accordance with the policy provisions.	I confirm that I know and understand this	consent I am providing to Momentum Corporate	and that I am doing so voluntarily.	
*If applicant is unable to sign the consent due to medical incapacity, please contact us so that we can further assist.  10b. Main Member's consent for Momentum to assess the Applicant's (i.e. Spouse's) eligibility for a disability benefit.  I provide consent for my spouse to submit a claim for disability benefits. I further give consent to Momentum Corporate to assess the claim and provide outcome in accordance with the policy provisions.				mber-document/)
10b. Main Member's consent for Momentum to assess the Applicant's (i.e. Spouse's) eligibility for a disability benefit.  I provide consent for my spouse to submit a claim for disability benefits. I further give consent to Momentum Corporate to assess the claim and provide outcome in accordance with the policy provisions.				M M - Y Y Y
benefit.  I provide consent for my spouse to submit a claim for disability benefits. I further give consent to Momentum Corporate to assess the claim and provide outcome in accordance with the policy provisions.				
outcome in accordance with the policy provisions.		or Momentum to assess the Applica	ant's (i.e. Spouse's) eligibility	for a disability
Signature of Main Member  Date DD - MM - YYYY			sent to Momentum Corporate to asses	s the claim and provide an
Signature of Main Member				M V V V
	Signature of Main Member		Date	

- Print out the form, sign and scan it and send it back via email to wcc@momentum.co.za , fax it to Fax +27 (0)21 917 3711 or posted to PO Box 2212, Bellville 7535, attention Momentum Group Insurance disability claims.
- Place your scanned signature in the signature block by following the steps outlined below.
  - Store your scanned signature as a PDF document 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.

corporate

## **Affidavit - Permanent Life Partner**

Title   First name   Sumame   RSA ID   Yes   No   ID / Passport no   Passport country of origin   Go hereby make oath and state as follows:   Image: Residential address   Postal code	I, the undersigned main member										
RSA ID  Passport country of origin  do hereby make oath and state as follows:  I am an adult male/female, residing at  Residential address  My contact details are:  Celiphone no  Tel no: Home  The facts contained in this affidavit fall within my personal knowledge, unless the contrary is expressly stated, and are to the best of my belief both true and correct.  I declare that the applicant  Title  Full name  Tel no: Home  Toll no: Home Toll no: Home  Toll no: Home  Toll no: Home Toll no: Home Tol	Title			First	name						
Passport country of origin do hereby make oath and state as follows:  I am an adult male/female, residing at Residential address    Postal code	Surname										
do hereby make oath and state as follows:  I am an adult male/female, residing at  Residential address    Postal code	RSA ID	Yes		No		ID / Passport no					
I am an adult male/female, residing at  Residential address    Postal code	Passport country of origin										
Residential address    My contact details are:	do hereby make oath and state as foll	ows:									
My contact details are:  Cellphone no  Tel no: Home  The facts contained in this affidavit fall within my personal knowledge, unless the contrary is expressly stated, and are to the best of my belief both true and correct.  I declare that the applicant  Title  Full name  RSA ID  Yes  No  ID / Passport no  Passport country of origin  is my permanent life partner since  we are living together in a joint household which we mutually share at  Residential address  We are financially dependent on each other;  The financial dependent amount is R  We have  children born from our union or jointly raised during our union namely  Full name  Date of birth  Date of birth	I am an adult male/female, residing	at									
My contact details are:  Cellphone no  Tel no: Home  The facts contained in this affidavit fall within my personal knowledge, unless the contrary is expressly stated, and are to the best of my belief both true and correct.  I declare that the applicant Title Full name  RSAID Yes No ID / Passport no  Passport country of origin  is my permanent life partner since DD MM YYYYY  we are living together in a joint household which we mutually share at  Residential address  We are financially dependent on each other;  The financial dependent amount is R per month  We have children born from our union or jointly raised during our union namely  Full name Date of birth DD MM YYYYY  Full name Date of birth DD MM M YYYYY  We share the following living expenses:	Residential address										
My contact details are:  Cellphone no  Tel no: Home  The facts contained in this affidavit fall within my personal knowledge, unless the contrary is expressly stated, and are to the best of my belief both true and correct.  I declare that the applicant Title Full name  RSAID Yes No ID / Passport no  Passport country of origin  is my permanent life partner since DD MM YYYYY  we are living together in a joint household which we mutually share at  Residential address  We are financially dependent on each other;  The financial dependent amount is R per month  We have children born from our union or jointly raised during our union namely  Full name Date of birth DD MM YYYYY  Full name Date of birth DD MM M YYYYY  We share the following living expenses:											
Celiphone no Tel no: Home  The facts contained in this affidavit fall within my personal knowledge, unless the contrary is expressly stated, and are to the best of my belief both true and correct.  I declare that the applicant Title Full name  RSAID Yes No ID / Passport no  Passport country of origin  is my permanent life partner since we are living together in a joint household which we mutually share at  Residential address  We are financially dependent on each other;  The financial dependent amount is R per month  We have children born from our union or jointly raised during our union namely  Full name Date of birth D N MM Y Y Y Y  Full name Date of birth D D N MM Y Y Y Y  Full name Date of birth D D N MM Y Y Y Y  Full name Date of birth D D N MM Y Y Y Y  Full name Date of birth D D N MM Y Y Y Y  Full name Date of birth D D N MM Y Y Y Y  Full name Date of birth D D N MM Y Y Y Y  Full name Date of birth D D N MM Y Y Y Y  We share the following living expenses:								Postal	code		
and correct.  I declare that the applicant Title Full name  RSA ID Yes No ID / Passport no  Passport country of origin  is my permanent life partner since	My contact details are: Cellphone no					Tel no: Home					
RSA ID  Passport country of origin  is my permanent life partner since  we are living together in a joint household which we mutually share at  Residential address  Postal code  since  Postal code  since  per month  We are financially dependent on each other;  The financial dependent amount is R  per month  We have children born from our union or jointly raised during our union namely  Full name  Date of birth	and correct.	within my	/ persoi	7		unless the contrary is expressly stated, and	are to	the best of	my be	lief both	n true
Passport country of origin is my permanent life partner since  we are living together in a joint household which we mutually share at  Residential address  We are financially dependent on each other;  The financial dependent amount is R  We have children born from our union or jointly raised during our union namely  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  We share the following living expenses:	I declare that the applicant Titl	е		Full r	name						
is my permanent life partner since    we are living together in a joint household which we mutually share at   Residential address	RSA ID	Yes		No		ID / Passport no					
we are living together in a joint household which we mutually share at  Residential address  Postal code  since DD - MM - YYYY  We are financially dependent on each other;  The financial dependent amount is R  We have children born from our union or jointly raised during our union namely  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  We share the following living expenses:	Passport country of origin										
Residential address    Postal code   Since   D - M M - Y Y Y Y	is my permanent life partner since	D D	- M	M -	Y	YYY					
We are financially dependent on each other;  The financial dependent amount is R per month  We have children born from our union or jointly raised during our union namely  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYYY  Full name Date of birth DD - MM - YYYYYY  Full name Date of birth DD - MM - YYYYYY  Full name Date of birth DD - MM - YYYYYY  We share the following living expenses:	we are living together in a joint ho	ousehold v	vhich w	e mutua	ally sha	re at					
we are financially dependent on each other;  The financial dependent amount is R per month  We have children born from our union or jointly raised during our union namely  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  We share the following living expenses:	Residential address										
we are financially dependent on each other;  The financial dependent amount is R per month  We have children born from our union or jointly raised during our union namely  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  We share the following living expenses:											
We are financially dependent on each other;  The financial dependent amount is R per month  We have children born from our union or jointly raised during our union namely  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  Full name Date of birth DD - MM - YYYYY  We share the following living expenses:								Postal	code		
The financial dependent amount is R	sino	e D D	_ M	М -	Y	YYY					
We have children born from our union or jointly raised during our union namely  Full name Date of birth DDD - MM - YYYYY  Full name Date of birth DDD - MM - YYYYY  Full name Date of birth DDD - MM - YYYYY  Full name Date of birth DDD - MM - YYYYY  Full name Date of birth DDD - MM - YYYYY  Full name Date of birth DDD - MM - YYYYY  We share the following living expenses:	We are financially dependent on	each othe	r;								
Full name  Date of birth  Date of bi	The financial dependent amount is	R				per month					
Full name  Date of birth  Date of bi	We have children bo	orn from o	ur unior	n or join	tly raise	ed during our union namely					
Full name  Date of birth  Date of bi	Full name					Date of birth	D	D _ M	Μ -	YY	YY
Full name  Date of birth  Date of bi	Full name					Date of birth	D	D _ M	Μ _	YY	YY
Full name  Date of birth  Date of bi	Full name					Date of birth	D	D _ M	M _	YY	YY
We share the following living expenses:	Full name					Date of birth	D	D _ M	Μ _	YY	YY
We share the following living expenses:	Full name					Date of birth	D	D _ M	M _	YY	YY
	We share the following living expe	enses:									
We jointly own the following assets and liabilities:											
We jointly own the following assets and liabilities:											
We jointly own the following assets and liabilities:											
	We jointly own the following asse	ts and liab	ilities:								

provide copies of relevant documents	on the following:	ir partiler silip with the applical	it with supporting evidence (please
Insurance policy			
I nominated the applicant			
as a beneficiary under my	ir	nsurance policy	
Policy Details			
Will and testament			
I nominated the applicant or the app	licant nominated me in our will under cla	ause	
Medical Aid			
I am covered under the applicant's r	medical aid or the applicant is covered u	ınder my medical aid	
Name of medical aid			
since	D D - M M - Y Y Y		
In addition, the following information	confirms my relationship to the appli	cant	
Signed at			
Deponent		Date	D D M M Y Y Y
Deponent			
I certify that: The Deponent acknowledged to me that:     He/She knows and understands the     He/She has no objection to taking the     He/She considers the prescribed or I certify that the Deponent knows and un	e contents of this declaration; he prescribed oath; ath to be binding on his/her conscience.		
The Deponent signed this declaration in	my presence at the address set out here	eunder	
Signed at			
		Date	
Commissioner of Oaths		Date	
Title	First name		
Surname			
Address			
			Postal code

corporate

# Affidavit - For marriages concluded under tenets of any other religion

I, the undersigned main member						
Title	Firs	t name				
Surname						
RSA ID	Yes No		I	D / Passport no		
Passport country of origin						
do hereby make oath and state as follow	/s:					
I am an adult male/female, residing at Residential address						
					Postal code	
My contact details are: Cellphone number				Tel no: Home		
The facts contained in this affidavit fall wand correct.	ithin my personal kno	owledge, unless	the contrary is expres	ssly stated, and are	to the best of my be	ief both true
I declare that the applicant Title	Ful	I name				
RSA ID	Yes No		I	D / Passport no		
Passport country of origin						
is my husband/wife since	D D - M M	- Y Y Y Y				
I confirm that our marriage is in terms of	Islamic law	Hindu law	Buddhist law	Other		
The marriage was performed by: Title	Firs	t name				
Surname						
(Religious leader/ Designation)						
Place						
I attach a copy of a certificate iss	ued by the authority	y (e.g. Muslim J	udicial Council).			
Signed at						
						VI VI VI VI
Deponent				Date	D - M M -	T Y Y Y

I certify that:

The Deponent acknowledged to me that:

- He/She knows and understands the contents of this declaration;
- He/She has no objection to taking the prescribed oath;
- He/She considers the prescribed oath to be binding on his/her conscience.

I certify that the Deponent knows and understands the contents of this declaration, which was sworn before me.

The Deponent signed this declaration in my presence at the address set out hereunder

Signed at				
Commissioner of Oaths	5	Date	D D _ M M _	Y Y Y Y
Title	First name			
Surname				
Address				
			Postal code	

corporate

# **Affidavit - African Customary Marriages**

I, the undersigned main member			
Title	First nam	e	
Surname			
RSA ID	Yes No	ID / Passport no	
Passport country of origin			
do hereby make oath and state as follow	vs:		
I am an adult male/female, residing at Residential address	:		
			Postal code
My contact details are:			
Cellphone no		Tel no: Home	
The facts contained in this affidavit fall wand correct.	ithin my personal knowled	ge, unless the contrary is expressly stated, and a	re to the best of my belief both true
I declare that the applicant Title	Full nam	е	
RSA ID	Yes No	ID / Passport no	
Passport country of origin			
is my husband/wife since	D D - M M - Y	YYY	
I confirm the following:  Our marriage is a customary union; (selection of the selection of	ect whichever is applicable	):	
Title	First nam	٩	
Surname	T not name		
paid lobola to my father/Guardian paren	t(e)		
Title	First nam	e	
Surname			
RSA ID	Yes No	ID / Passport no	
Passport country of origin			
with my and my father's consent on	D D - M M - Y	that being our date of marriage;	
or  My family and I paid lobola to my sp	oouse's father/Guardian pa	rent	
Title	First nam	e	
Surname			
RSA ID	Yes No	ID / Passport no	
Passport country of origin			
with the intent of making her my lawful w	vife as per the custom on	DDD - MM - YYYY that being	our date of marriage.
I attach a copy of the following	Copy of lobolo letter	Certificate issued by any council or authority	(select whichever is applicable)
Signed at			
Deponent		Date	D D . M M . Y Y Y

#### I certify that:

The Deponent acknowledged to me that:

- He/She knows and understands the contents of this declaration;
- He/She has no objection to taking the prescribed oath;
- He/She considers the prescribed oath to be binding on his/her conscience.

I certify that the Deponent knows and understands the contents of this declaration, which was sworn before me.

The Deponent signed this declaration in my presence at the address set out hereunder

Signed at					
(	Commissioner of Oaths		Date	D D - M M -	Y Y Y Y
Title		First name			
Surname					
Address					
				Postal code	