

## 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](mailto: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  -  -   
RSA ID  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  -  -   
Company/employee No

#### 4. Applicant (Spouse) details.

Title	<input type="text"/>	Initials	<input type="text"/>
First name/s	<input type="text"/>		
Surname	<input type="text"/>		
Date of birth	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
RSA ID	Yes <input type="checkbox"/>	No <input type="checkbox"/>	ID / Passport no <input type="text"/>
Passport country of origin	<input type="text"/>		
Postal address	<input type="text"/>		Postal code <input type="text"/>
Contact number	<input type="text"/>		
Email	<input type="text"/>		
Relationship to main member	Spouse <input type="checkbox"/>	Permanent Life Partner <input type="checkbox"/>	

#### 5. Occupational information (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 current employer    -    -

Date when you started in your current occupation/position    -    -

Job title

Details of duties. List five key activities and give a brief description of each.

1.

2.

3.

4.

5.

Date last able to actively perform your normal occupation    -    -

When do you expect to be able to take up any occupation in the future?

On a part-time basis?    -    -     On a full-time basis?    -    -

What is your current employment status? Please tick the appropriate box.

Working full-time <input type="checkbox"/>	Working part-time <input type="checkbox"/>	On sick leave <input type="checkbox"/>	On unpaid leave <input type="checkbox"/>
Laid off or retrenched <input type="checkbox"/>	Dismissed <input type="checkbox"/>	Other <input type="checkbox"/>	

If Other, please specify.

Have you been able to perform part of your job, or another job, since your impairment? Yes  No

What duties can you no longer do?

What duties can you still do?

If you have performed another job, or if your job was changed at all due to your medical condition, please give details of the adapted duties that you did, the date that your duties changed, and salary that you were paid for this adapted job.

Details of the adapted duties	Date duties changed	Salary

Apart from your present occupation, please supply a brief employment history, including previous positions held at current and previous employers.

Date started	Date ended	Company	Position held	Type of work	Salary at date of leaving	Reason for leaving

Details of your qualifications, training and experience

	Year achieved	Standard/Qualification
Highest level of schooling		
Technical qualifications (NTC, diplomas, etc.)		
Academic qualifications (e.g. degrees, etc.)		
Other training (e.g. certificates, in-house training, driver's licences & codes)		

What alternative occupation/s do you consider yourself qualified for?


## 6. Medical information (to be completed by the applicant).

List of diagnoses/symptoms/complaints.


Date first noticed

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

How does the impairment affect you in doing your normal every day tasks at home? What can you no longer do and what can you still do?


Have you, in the last 5 years, suffered from any serious disease, illness or disablement?

Yes

No

If Yes, please provide details.


Details of any hospitalisations within the last 2 years.

Name of hospital	Date of admission	Date of discharge	Reason for admission	Surgery performed (if applicable)

Current treatment. Please list all medication you are on, provide name and dosage.


Please give the names of all doctors, specialists and hospitals you have consulted in connection with your impairment/disability. Please provide us with the telephone number and email address as we may need this to communicate with your doctor.

Date from				
Date to				
Hospital / Doctor				
Speciality				
Tel no.				
Email address				
Patient Number				

Please give the name, address, email address and tel number of your regular family doctor/general practitioner.

Name

Address

Postal code

Tel No.  Fax

Email

Date that you first visited your current general practitioner   -   -

When was your last consultation?   -   -

If you have changed general practitioners in the last two years, please give details of all previous attending general practitioner/s.

Dates		Doctor's name	Hospital/Practice name	Tel no
From	To			

Indicate your ability to perform Activities of Daily Living.

Basic	Able		Not able		Advanced	Able		Not able	
Control bowels					Driving a car				
Control bladder					Medical care: prepares and takes correct medication				
Grooming					Money management				
Toileting					Communicative activities: use of phone, writing letters				
Feeding					Shopping: lifting or carrying groceries				
Transfers from chair to bed					Food preparation				
Indoor mobility					Housework				
Dressing					Community ambulation with or without assistive device.				
Stairs					Moderate activities: moving table, pushing vaccum cleaner, bowling, golf				
Bathing					Vigorous activities: running, heavy lifting, sports				

## 7. Banking details.

To whom must benefit be paid?  Main member's employer  Main member

Name of account holder

Name of bank

Account number  Branch no.

Account type  Current/cheque  Savings  Transmission

## 8. Supporting documents required.

I have attached a copy of the main member's payslip

Yes	<input type="checkbox"/>
-----	--------------------------

No	<input type="checkbox"/>
----	--------------------------

I have attached a copy of my job description (if employed)

Yes	<input type="checkbox"/>
-----	--------------------------

No	<input type="checkbox"/>
----	--------------------------

I have attached a copy of my leave records for the past 2 years from my employer.

Yes	<input type="checkbox"/>
-----	--------------------------

No	<input type="checkbox"/>
----	--------------------------

I have attached a copy of my marriage certificate (if a registered marriage)

Yes	<input type="checkbox"/>
-----	--------------------------

No	<input type="checkbox"/>
----	--------------------------

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 tenets of any other religion, or a Permanent Life Partner)

Yes	<input type="checkbox"/>
-----	--------------------------

No	<input type="checkbox"/>
----	--------------------------

## 9. Declaration by main member's employer.

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 management of this claim.

I declare that I have the necessary authority 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

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

**10. Consent.**

**10a. Applicant's (i.e. Spouse's) declaration and consent to collect and share personal and health information**

First name/s

Surname

RSA ID  Yes  No  ID / Passport no

Passport country of origin

**Declaration**

I  (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 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 confidentiality of my personal information. Momentum Corporate's full privacy policy can be found on [www.momentum.co.za](http://www.momentum.co.za).

I consent 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, 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 or any third party nominated by Momentum Corporate who requires this information for the purposes of assessing and managing my claim.
- 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, allied health practitioner, health risk management service provider appointed by the policyholder, or any third party nominated by Momentum Corporate who may require such information for the purpose of assisting Momentum Corporate in the assessment and management of my 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 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 against that insurer, and with Astute for statistical purposes and for the management of over insurance and fraud in the insurance industry.
- Momentum Corporate to send correspondence which may include personal and special personal information, regarding my claim to the policyholder or its duly appointed intermediary. The purpose of this correspondence is to inform them of the status and outcome of my claim.
- Momentum Corporate to provide the policyholder or its duly appointed intermediary with regular claims status reports which will contain personal information. Momentum Corporate will not share any health related information in the status reports unless I have given express written consent.
- Momentum Corporate to share all medical and health related information (special personal information) with the following third parties (please select from the list below):

- Policyholder (including policyholder representatives) involved with my claim
- Financial Advisers and Intermediaries appointed by the policyholder or myself
- Any other person/s appointed by me in writing
- All of the above
- None of the above

Momentum Corporate will share medical and health related information with third parties as consented above at its sole discretion. I hereby confirm that I will not hold Momentum Corporate, its employees, directors, or agents liable in any way and I indemnify and hold Momentum Corporate harmless for the sharing of health related information in line with this consent.

I confirm that I know and understand this consent I am providing to Momentum Corporate and that I am doing so voluntarily.

[Click here](https://www.momentumpartnershipconnect.co.za/momentum-corporate-popia-member-document/) to read the full consent document. (<https://www.momentumpartnershipconnect.co.za/momentum-corporate-popia-member-document/>)

**Signature of Applicant**

**Date**    -    -

**\*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 an outcome in accordance with the policy provisions.

**Signature of Main Member**

**Date**    -    -

- 
1. Print out the form, sign and scan it and send it back via email to [wcc@momentum.co.za](mailto: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.
  2. 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.

## Affidavit - Permanent Life Partner

**I, the undersigned main member**

Title  First name

Surname

RSA ID  Yes  No  ID / Passport no

Passport country of origin

do hereby make oath and state as follows:

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

we are living together in a joint household which we mutually share at

Residential address

Postal code

since  D  D -  M  M -  Y  Y  Y  Y

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	<input type="text"/>	Date of birth	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y
Full name	<input type="text"/>	Date of birth	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y
Full name	<input type="text"/>	Date of birth	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y
Full name	<input type="text"/>	Date of birth	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y
Full name	<input type="text"/>	Date of birth	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y

We share the following living expenses:

We jointly own the following assets and liabilities:

Please provide specific detail/s that can objectively prove/substantiate your partnership with the applicant with supporting evidence (please provide copies of relevant documents) on the following:

**Insurance policy**

I nominated the applicant

as a beneficiary under my  insurance policy

Policy Details

**Will and testament**

I nominated the applicant or the applicant nominated me in our will under clause

**Medical Aid**

I am covered under the applicant's medical aid or the applicant is covered under my medical aid

Name of medical aid

since    -    -

**In addition, the following information confirms my relationship to the applicant**

Signed at

**Deponent**

Date

-    -

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

-    -

Title

First name

Surname

Address

Postal code

Momentum Metropolitan Life Limited

268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa  
The Marc, 129 Rivonia Rd, Sandown, Sandton 2196, PO Box, Sandton, South Africa Tel +0860 65 75 85 Fax +27 (0)12 675 3970  
Parc du Cap 4, Mispel Road, Bellville, Cape Town 7530, PO Box 2212, Bellville 7535, South Africa Tel +27 (0)21 940 5911 Fax +27 (0)21 940 4320  
momentumcorporateclient@momentum.co.za www.momentum.co.za/momentum/business

Momentum Corporate is a part of Momentum Metropolitan Life Limited (registration number 1904/002186/06), a licensed life insurer, authorised financial services and registered credit provider.

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

**I, the undersigned main member**

Title  First name

Surname

RSA ID  Yes  No  ID / Passport no

Passport country of origin

do hereby make oath and state as follows:

**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 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 husband/wife since   -   -

I confirm that our marriage is in terms of  Islamic law  Hindu law  Buddhist law  Other

The marriage was performed by: Title  First name

Surname

(Religious leader/ Designation)

Place

I attach a copy of a certificate issued by the authority (e.g. Muslim Judicial Council).

Signed at

**Deponent**  **Date**    -   -

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

Momentum Metropolitan Life Limited

268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa

The Marc, 129 Rivonia Rd, Sandown, Sandton 2196, PO Box, Sandton, South Africa Tel +0860 65 75 85 Fax +27 (0)12 675 3970

Parc du Cap 4, Mispel Road, Bellville, Cape Town 7530, PO Box 2212, Bellville 7535, South Africa Tel +27 (0)21 940 5911 Fax +27 (0)21 940 4320

momentumcorporateclient@momentum.co.za www.momentum.co.za/momentum/business

Momentum Corporate is a part of Momentum Metropolitan Life Limited (registration number 1904/002186/06), a licensed life insurer, authorised financial services and registered credit provider.

## Affidavit - African Customary Marriages

**I, the undersigned main member**

Title  First name

Surname

RSA ID  Yes  No  ID / Passport no

Passport country of origin

do hereby make oath and state as follows:

**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 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 husband/wife since   -    -

I confirm the following:

Our marriage is a customary union; (select whichever is applicable):

My husband

Title  First name

Surname

paid lobola to my father/Guardian parent(s)

Title  First name

Surname

RSA ID  Yes  No  ID / Passport no

Passport country of origin

with my and my father's consent on   -    -       that being our date of marriage;

**or**

My family and I paid lobola to my spouse's father/Guardian parent

Title  First name

Surname

RSA ID  Yes  No  ID / Passport no

Passport country of origin

with the intent of making her my lawful wife as per the custom on   -    -       that being our date of marriage.

**I attach a copy of the following**  Copy of lobola letter  Certificate issued by any council or authority  (select whichever is applicable)

Signed at

**Deponent**

**Date**   -    -

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		<input type="text"/>											
<b>Commissioner of Oaths</b>		<input type="text"/>					Date		<input type="text"/>			<input type="text"/>	
Title	<input type="text"/>	First name	<input type="text"/>										
Surname	<input type="text"/>												
Address	<input type="text"/>												
	<input type="text"/>												
	<input type="text"/>							Postal code	<input type="text"/>				

Momentum Metropolitan Life Limited

268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa

The Marc, 129 Rivonia Rd, Sandown, Sandton 2196, PO Box, Sandton, South Africa Tel +0860 65 75 85 Fax +27 (0)12 675 3970

Parc du Cap 4, Mispel Road, Bellville, Cape Town 7530, PO Box 2212, Bellville 7535, South Africa Tel +27 (0)21 940 5911 Fax +27 (0)21 940 4320

momentumcorporateclient@momentum.co.za www.momentum.co.za/momentum/business

Momentum Corporate is a part of Momentum Metropolitan Life Limited (registration number 1904/002186/06), a licensed life insurer, authorised financial services and registered credit provider.