momentum

Income disability and impairment benefits

Policy number										

Requirements

In order for Momentum to process your claim, the following is required:

Requirements	Income Protector	Temporary Income Protector	Business Overhead Protecor	Business Protector
A completed claim form	✓	✓	✓	✓
A certified copy of your identity document	✓	✓	✓	✓
A copy of the medical certificate from a medical specialist that confirms the injury or illness and the exact period of sick leave	✓	✓	✓	✓
A copy of the hospital account *(only applicable if you claim for hospitalisation)*	✓	✓	✓	✓
Certified proof of your income for the past 12 months before the date on which you were diagnosed with the claim event. This may include salary slips, tax returns, bank statements and audited statements	✓ You have six months to provide proof of income after the claim event occurs	✓ You have six months to provide proof of income after the claim event occurs	✗	✓ You have six months to provide proof of income after the claim event occurs
A certified copy of the accident report from the SAPS or your employer *(only applicable if the claim event was caused by an accident)*	✓	✓	✓	✓
A certified copy of the official proof of the business' overhead expenses for the past 12 months	✗	✗	✓ You have three months to provide proof of pre-disability business overhead expenses	✗
A copy of a cancelled cheque or a bank statement in the name of the policyholder	✓	✓	✓	✓
Curator bonis appointment if the claimant is not able to handle his/her own financial affairs	✓	✓	✓	✓

We may require additional information. You must provide us with written notice of a claim within six months of the claim event. Before we admit a claim, we reserve the right to have the insured life examined by a doctor that we have chosen.

Financial adviser details

* Please complete details of servicing financial adviser.

Name	Financial adviser's code	Broker house code
*		

Marketing adviser details

Name | Marketing adviser's code

Branch name | Telephone number

Section 1: Policyholder details

Title | Initials | First name

Surname

Previous surname(s)

Gender: Male | Female | Correspondence language: English | Afrikaans

Date of birth: D D – M M – Y Y Y Y | Nationality

Permanent identity number | Permanent RSA ID: Yes | No

Postal address

Postal code

Residential address

Postal code

Telephone - work | Fax - work

Telephone - home | Fax - home

Cellphone number

E-mail address

Section 2: Insured life details

A. Fill in if this client is the insured life

Title | Initials | First name

Surname/name of legal entity

Previous surname(s)

Contact person in case of legal entity

Gender: Male | Female | Correspondence language: English | Afrikaans

Date of birth: D D – M M – Y Y Y Y | Nationality

Permanent identity number | Permanent RSA ID: Yes | No

Postal address

Postal code

Residential address

Postal code

Telephone - work | Fax - work

Telephone - home | Cellphone number

E-mail address

Income tax number

Income tax office

Section 3: Medical aid details

Medical aid name

Medical aid membership number

Medical aid telephone number

Usual pharmacy

Section 4: Occupational history

Please provide details of your career, including your present and/or last occupation. The exact dates (at least month and year) of the commencement and termination of your service are required.

Name of employer

Address

Postal code

Telephone number

Job title and occupation

Nature of work

Date of commencement D D – M M – Y Y Y Y

Date of termination D D – M M – Y Y Y Y

Name of employer

Address

Postal code

Telephone number

Job title and occupation

Nature of work

Date of commencement D D – M M – Y Y Y Y

Date of termination D D – M M – Y Y Y Y

What was the last date on which you were actively able to do your work? D D – M M – **2 0** Y Y

(Not necessarily the date of termination of service.)

Describe the most important duties of your occupation(s) from which you earned an income immediately before your disability (date as stated above).

Below, state the percentages of time engaged in the following duties, as well as a detailed description of these duties prior to your disability. (Note: The percentages must add up to 100%)

					Description
Administrative duties				%	
Manual/physical duties				%	
Supervisory duties				%	
Travelling by car, truck, etc.				%	
Walking and standing				%	
Total	1	0	0	%	

Highest educational qualification (e.g. Std. 10/Gr. 12 or B.Com)

Other qualifications obtained

Skills and/or courses acquired while in service

Section 5: Medical information

5.1 Details for occupational disability claims

Please state the nature of the injuries or illness that caused your disability:

Describe the symptoms that you are experiencing:

On which date did you first experience any symptoms? D D – M M – 2 0 Y Y

On which date did you first consult a doctor regarding these symptoms? D D – M M – 2 0 Y Y

Describe how the symptoms mentioned above have affected your ability to perform the duties of your own occupaton:

Are you still able to perform some of your occupational duties? Yes ☐ No ☐

If yes, please indicate to what extent (in percentage) you are still able to perform the following duties (where applicable). (E.g. if you are able to perform all administrative duties, indicate 100%. Only complete for duties that you were engaged in prior to your disability.)

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

Are you still working a full working day? Yes ☐ No ☐

If No, please state the number of hours you are currently working

List and describe the duties you are no longer able to perform:

Describe how being unable to perform these duties have limited your ability to perform your normal daily duties (e.g. has your output and work been affected and in what way):

What was the last date on which you were actively able to do your work (where applicable)? D D – M M – 2 0 Y Y

(Not necessarily the date of termination of service.)

Date of official discharge (where applicable) D D – M M – 2 0 Y Y

Have you been hospitalised for special examinations or treatment? Yes ☐ No ☐

If yes, please provide details:

Name of hospital	Date of admission	Date of discharge	Patient number
	D D – M M – 2 0 Y Y	D D – M M – 2 0 Y Y	
	D D – M M – 2 0 Y Y	D D – M M – 2 0 Y Y	
	D D – M M – 2 0 Y Y	D D – M M – 2 0 Y Y	
	D D – M M – 2 0 Y Y	D D – M M – 2 0 Y Y	
	D D – M M – 2 0 Y Y	D D – M M – 2 0 Y Y	

Section 5: Medical information (continued)

5.2 Details for funtional impairment, critical illness and fracture and hospitalisation claims

Functional impairment and critical illness claims

For functional impairment or critical illness claims, the claims department will request the relevant medical reports and documentation necessary to assess the claims.

Fracture and hospitalisation

Please indicate the injury for which you are claiming. Please provide all medical proof to support the claim (e.g. X-rays, specialist report and proof of hospitalisation).

Thigh	Pelvis	Leg between knee and foot	Forearm above the wrist
Kneecap	Upper arm	Shoulder blade	Hand requiring plaster or surgery
Collarbone	Hospitalisation longer than a week		

Section 6: Medical doctor of the insured life

Confidential correspondence:

Surname Initials

Telephone - work

Postal address

Postal code

Current/most recent doctor (if other than the above)

Surname Initials

Telephone - work

When did he/she become your regular doctor? D D – M M – Y Y Y Y

Details of other doctors, specialists and consulations

Name and surname

Type of specialist

Postal address

Postal code

Telephone - work

Name and surname

Type of specialist

Postal address

Postal code

Telephone - work

Section 7: Accident details

Complete only if your disability has been caused by an accident.

Date of accident D D – M M – Y Y Y Y

Place of accident

Accident was caused by

Motor vehicle accident	Accident at work	Accident at home
Shooting accident	Other	

Provide a brief description of the circumstances surrounding the accident:

Section 7: Accident details (continued)

If there was an investigation into the cause of the accident, please provide a complete copy of the accident report.

Police station

Case number

Telephone number

Fax number

Section 8: Additional benefit information

A. Income Protector and Temporary Income Protector

Income used in determining the benefit amount is defined as one of the following:

Gross Taxable Income

Taxable income payable or benefits receivable on account of the insured life's employment, or any services rendered by the insured life.

Cost to Company Income

This equals Gross Taxable Income plus the value of the use of a motor vehicle, as well as the employer's contributions to a medical scheme and a pension fund and the cost of any other benefits paid for by the insured's employer and drawings in the form of dividends.

Gross Professional Income (professionals only)

For professionals that charge a fee for services, this equals the sum of the professional fee and the net income from trading activities, after deducting business overheads expenses.

1. Details of income
   - 1.1 What was your average monthly income from your occupation for the 12 months preceding your disability? R
   - 1.2 What amount of this income is based on commission? R
   - 1.3 Income from other sources (other occupations, investments, rentals, etc.) will not be taken into account when determining your income. Do you receive such income? Yes No

     If Yes, please provide details:
2. If self-employed, is the business based at your home? Yes No

B. Business Overheads Protector

1. Number of employees
2. Number of employees with your professional or trade qualifications
3. Details of your interest in the business:
   - 3.1 Total monthly overhead expenses R
   - 3.2 Your percentage (%) share of overhead expenses
   - 3.3 Percentage (%) of business turnover from sale of goods
   - 3.4 Number of associates
   - 3.5 Your percentage (%) share of the business
4. If self-employed, is the business based at your home? Yes No

C. Business Protector *(Only for professionals)*

Your income will be based on the sum of the professional fees, plus net income from trading activities.

What was your average monthly fee income and net income from trading activities in the 12 months preceding your disability?

R

Section 9: Bank particulars

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

9.1 Income tax

When income payments are made to a natural person, we will deduct tax in advance due to our obligations under the Income Tax Act and pay this over to SARS. If you provide us with a tax directive from SARS, we will deduct tax according to the directive.

9.2 Payment to the owner of the policy

If your claim is admitted, Momentum can make your money available by means of an electronic bank transfer. Please provide the following details:

Bank

Branch name

Account number | Six-digit branch code

Name of account holder

Account type | Current | Savings | Transmission

I, the undersigned, hereby declare that if the above information is incorrect, Momentum cannot be held liable for any loss that may arise from the use of this information.

Signature of account holder **Date** D D – M M – **2 0** Y Y

Please note: If any plan in terms of which a claim is admitted, has been ceded to another institution or person, payment will be made directly to the cessionary in question. The next section must be completed by the cessionary, if applicable.

9.3 Payment to cessionary

Complete if any of your plans are ceded:

Bank

Branch name

Account number | Six-digit branch code

Name of account holder

Account type | Current | Savings | Transmission

OR

I hereby give permission for the cession to be cancelled

Name of contact person

Contact number

Official stamp of institution

Signature of cessionary **Date** D D – M M – **2 0** Y Y

Section 10: Declaration by applicant(s), insured life/lives and fund member

I accept and understand that I am limiting my right to privacy. To enable the assessment of the risks and the calculation of the premium and to assist in considering any claim for benefits as a result of this, or any other application for insurance that I have made, or that was made for me as the insured life, I authorise the Momentum Group Limited (Momentum), including their current and future subsidiaries and/or representatives:

- to obtain from any person, any information that Momentum requires for purposes of underwriting this application and/or claims arising from this policy. I authorise such person(s) to give the said information to Momentum, and
- to share with other insurers any information in this application or in any related policy 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 Momentum or the operators of such database may decide from time to time, and
- to disclose my medical information to any parties that Momentum uses in providing services in connection with the policy. I acknowledge that I cannot cancel this authorisation and that it will endure after my death.

Section 11: Signatures

I acknowledge that I have read the declaration above, that I fully understand its nature and effect and that it will be binding.

Signed at | | | | | | | | | | | | | | | | | | | | | | | | | **Date** D D – M M – **2 0** Y Y

Signature(s)

Client number | | | Signature of parent/guardian or trustee (if applicable)

Client number | | | Client number | |

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