momentum

Income disability and impairment benefit claim

Policy number											

You have a say in how Momentum treats your personal information. We abide by confidentiality principles and the Protection of Personal Information Act. You voluntarily give us your consent to collect, record, store and use (process) your information including special information for the purposes of processing and assessing this claim, and related transactions and to share it with our partners and contracted service providers who are legally bound to the same principles. Your personal information is collected and processed by our staff, representatives, reinsurance partners or sub-contractors. We will make every reasonable effort to protect and secure your personal information. To assess your claim, we may need to share your information with others in the Momentum Metropolitan Group or contracted service providers (both locally and abroad). Momentum Metropolitan Group will make sure that the contracted service providers agree to our privacy and security policies if they need access to your personal information for claims and statistical purposes.

You can access your information at any time and ask us to change or correct it. You may object to us using your personal information except when we need it to conclude business transactions with you, or to fulfil our legal obligations. You also have a right to request that we delete your personal information in our possession if we no longer legally require it. If you think your personal information is being tampered with, or that it has not been protected, please refer your complaints to our internal data privacy team at **dataprivacy@momentummetropolitan.co.za.** Should you not be satisfied with the outcome, you may refer your case to government's Information Regulator at **inforeg@justice.gov.za** or contact them on **012 406 4818.**

Contact details

To submit a claim, follow up on a claim, or to provide us with additional required documentation, you can contact us in any of the following ways. Our office hours are from 8:00 – 17:00.

E-mail: **incomeclaims@momentum.co.za**
Fax: **+27 12 675 3947** (Please quote the policy number on the fax.)

Or call us for more information:

Sharecall (South Africa): **0860 44 11 11**
Tel: **+27 12 675 3052**
International: **+27 11 505 1552**

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	✗

Requirements (continued)

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.

Preferred communication

As part of our claim's process we will keep your servicing financial adviser on our system informed of the progress of the claim.

Should you not wish the servicing financial adviser to remain informed of the progress of the claim, please indicate with a tick. ☐

In the event that you selected the above option, you will be responsible to submit all claim documentation to Momentum directly.

Name and surname

Signature **Date** D D M M Y Y Y Y

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 ID Yes ☐ No ☐

Postal address

Postal code

Residential address

Postal code

Telephone - work Fax - work

Telephone - home Fax - home

Cellphone number

E-mail address

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 ID Yes ☐ No ☐

Postal address

Postal code

Residential address

Postal code

Telephone - work Fax - work

Telephone - home Cellphone number

E-mail address

2: Insured life details (continued)

A. Fill in if this client is the insured life (continued)

Income tax number

Income tax office

3: Medical aid details

Medical aid name

Medical aid membership number

Medical aid telephone number

Usual pharmacy

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 Y Y 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

5: Medical information

5.1 Details for occupational disability claims

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 Y Y Y Y

On which date did you first consult a doctor regarding these symptoms? D D M M Y Y 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”, 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”, 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 Y Y Y Y

(Not necessarily the date of termination of service.)

Date of official discharge (where applicable) D D M M Y Y Y Y

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

If “yes”, provide details:

Name of hospital	Date of admission	Date of discharge	Patient number
	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	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	

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 ☐		

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

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:

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

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?
   - 1.2 What amount of this income is based on commission?
   - 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", 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
   - 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?

9: Bank particulars

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

9.1 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 Y Y 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.

9.2 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 Y Y Y Y

10: Disclaimer

Momentum will take all reasonable steps to ensure the security and confidentiality of the information submitted. Momentum also ensures the integrity and security of its electronic data systems and warrants that it will comply with all relevant legislation relating to electronic communications. However, Momentum will accept no liability for loss or damages of any nature resulting from:

- Your negligent usage of this electronic platform for transactional purposes or that of your Representative.
- The claim data being incorrectly captured by you or on your behalf.
- The payment details or the payee details being incorrect.

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

I accept that I am personally responsible for the cost of this examination and any other supporting reports or documentation required by Momentum to process the claim.

The policyholder/insured life accepts and understands the limitation of their right to privacy by signing this claim form. To enable the assessment of any claim for benefits, the policyholder and/or the insured life authorises Momentum to:

- Obtain from any person, other insurer, medical aid, medical practitioner/institution, or any other company/companies, any information that Momentum requires for assessing and processing this claim. The policyholder/insured life authorises such person(s) to give the information to Momentum;
- Share with other insurers for the purposes of assessing and processing the claim, any information in this form or in any related policy or other document, either directly or through a database operated by or for insurers as a group and in such detailed, abbreviated or coded form as Momentum or the operators of such database may decide from time to time, and
- Disclose my medical information to any parties that Momentum uses in providing services in connection with the policy.

12: 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 Y Y Y Y

Signature(s)

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

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