momentum

Disability claim - employee declaration

Employee/claimant to complete this form

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

This declaration will form the basis on which the claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Distortion of information could be used as a basis for the claim being declined.

Please attach the following:
- A copy of your ID/passport

We will also require the Disability Claim Employer Declaration and 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 +264 61 234 851 or emailed to ebnamdisability@momentum.com.na or posted to PO Box 3785, Windhoek 9000, attention Momentum Employee Benefits disability claims.

1. Scheme details

Scheme name:

Employer name:

2. Member details

Title | Initials

First name/s

Surname

Date of birth: D D - M M - Y Y Y Y

Namibian ID: Yes | No | ID/Passport No.

Passport country of origin

Gender: Male | Female

Marital status: Married | Single | Divorced | Widowed

Home language

Telephone - work | Fax

Telephone - home | Cell

Email

Residential address

Postal code:

Postal address

Postal code:

Income tax office

Income tax number

Do you belong to a medical aid? Yes | No

If yes, give details
Name of scheme:

Membership no: | When did you join? Give date: D D - M M - 2 0 Y Y

When will your membership stop/when do you expect it to stop? D D - M M - 2 0 Y Y

3. Details of occupation

Date when you started working for your current employer: D D - M M - 2 0 Y Y

Date when you started in your current occupation/position: D D - M M - 2 0 Y Y

Job title

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

1.

2.

3.

4.

5.

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

If you have performed another job, or if your job was changed, please give details of the job that you did, the date that it changed/started, and salary that you were paid.

4. Details of employment history

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

5. 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. Details of impairment

Date last able to actively perform your normal occupation: D D - M M - 2 0 Y Y

an alternative occupation: D D - M M - 2 0 Y Y

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

On a part-time basis? D D - M M - 2 0 Y Y On a full-time basis? D D - M M - 2 0 Y Y

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

Working full-time	Working part-time	On sick leave	On unpaid leave
Laid off or retrenched	Dismissed	Other	

If Other, please specify

Please complete if your impairment arose from an accident or other violent means:

Date of accident: D D - M M - 2 0 Y Y

What type of accident/incident occurred?

Police station where reported:

Police case number:

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

How does the impairment affect you in doing your normal duties?

Which duties can you no longer do?

Which duties 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

6. Details of impairment (continued)

Please give the names of all doctors, specialists and hospitals you have consulted in connection with your impairment/disability.

Dates					
From	To	Hospital / Doctor	Speciality	Tel no.	Patient Number

Please give the name, address and telephone number of your regular family doctor/general practitioner:

Name

Postal address

Postal code:

Tel No.

Date that you first visited your current general practitioner D D - M M - 2 0 Y Y

When was your last consultation? D D - M M - 2 0 Y Y

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

Dates				
From	To	Doctors name	Hospital/Practice name	Tel no

7. Current activity profile

Please indicate your hobbies and interests:

Please indicate how you generally spend your day since you have been suffering from the impairment:

06h00 - 07h00	
07h00 - 08h00	
08h00 - 09h00	
09h00 - 10h00	
10h00 - 11h00	
11h00 - 12h00	
12h00 - 13h00	
13h00 - 14h00	
14h00 - 15h00	
15h00 - 16h00	
16h00 - 17h00	
17h00 - 18h00	
18h00 - 19h00	
19h00 - 20h00	
20h00 - 21h00	
21h00 - 22h00	

8. Income detail

Income prior to your impairment

Normal salary or wages per month	Bonuses or overtime (monthly average last year)	Commission (monthly average last year)	Other

Current or expected future income

Source of income eg employer, self employment, other insurer, UIF, workman's compensation etc			
Amount of income			
How payable (monthly, lump sum)			
Date of commencement of payment			
Policy number/s (if applicable)			

9. Employee banking details

Name of account holder

Name of bank

Account number: Branch no.:

Account type: Current/cheque savings transmission

10. Supporting documents required

I have included a copy of my ID Document Yes No

11. Declaration & Consent to collect and share personal and health information

Declaration
I declare that to the best of my knowledge all the particulars given on this claim form are true and correct, and that no material information has been withheld or omitted. I understand that any false and/or misrepresentation of information could be used as a basis for the claim being declined.

Consent to collect and share personal and health information
I hereby consent and authorise:

- any health practitioner (e.g. medical practitioner, dentist, occupational therapist, psychologist, etc.), allied health practitioner , hospital, medical aid, employer, insurance company, health risk management service provider appointed by my employer or any other person who has information about my health, employment related activities and personal information, to provide such information to MMI Group Limited ("MMI") or any 3rd party nominated by MMI who requires this information for the purposes of assessing my claim.
- MMI to furnish 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, to a health practitioner, allied health practitioner, health risk management service provider appointed by my employer, or any 3rd party nominated by MMI who may require such information for the purpose of assisting MMI in the assessment of my claim or for assessing the payment of a benefit provided for in a risk policy where I am the policyholder.
- MMI to furnish my employer or its duly appointed intermediary with regular claim status reports which will contain personal information but not any health related information unless I have given my express consent for this information to be provided.

Signature of Member

D D - M M - 2 0 Y Y

Date

Options to sign the form:

1. Print out the form, sign and scan it and send it back via email to ebnamdisability@momentum.com.na , fax it to Fax +26 (4)61 234 851 or posted to PO Box 3785, Windhoek 9000, attention Momentum Employee Benefits disability claims.

2. Place your scanned signature in the signature block.
   - Store your scanned signature in a safe place on your computer.
   - Select the 'comments' tab from your menu in Adobe.
   - Select the 'add stamp' icon.
   - Select custom stamps.
   - Create custom stamps.
   - You can now browse and upload your signature to save it as a custom stamp under 'sign here' in Adobe.
   - You can now go back to your 'stamps' icon and select 'sign here' and select your saved signature.
   - Place it in the document and save the document.

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