# Disability claim - Claimant's statement

Discovery Group Risk
GRF99

Discovery

**Contact details**

Telephone 0860 543 322, email: groupriskclaims@discovery.co.za, PO Box 3888, Rivonia 2128, www.discovery.co.za.

## How to complete this form

### Purpose on the form

This form is the claimant's statement for the their claim under their Discovery Group Risk policy. It is your responsibility as the claimant to complete the form in respect of your Income Continuation Benefit, Severe Illness Benefit and/or Capital Disability Benefit and send it to us.

### Steps to completing this form

1. This form must be completed by the member (claimant).
2. Answer all questions, do not leave any questions blank (unless noted as optional) or cross any out.
3. You can complete the form electronically or print it out and complete it by hand.
4. Please complete all information in black ink, write one letter per block and print clearly.
5. To avoid any administrative delays or errors, please ensure this form is completed in full with accurate information and signed, and that the necessary supporting documents are attached.
6. Email the form to groupriskclaims@discovery.co.za.

If you do not understand any questions on the form contact Discovery Group Risk or a medical doctor.

## Employer or Policyholder details

Employer name

Group scheme name

Group scheme number

## Member details

Surname

First names

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

ID/passport number

Passport expiry date D D - M M - Y Y Y Y

Gender Male Female

Nationality

Residential address

Code

Cellphone number

Telephone number

Email address

**Medical scheme details**

Medical scheme name

Membership number

Principal member's name

Medical scheme premium per month **R**

Vitality premium per month **R**

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## Details of next of kin

Surname

First names

Relationship to claimant

Cellphone number

Telephone number

Email address

## Details of Group Risk Life Plan - Additional benefits

### Contribution Protector

Which Group Risk Life Plan policy are you on?

Core plan (12 months)

Comprehensive plan (24 months)

| Product | Policy/Member number | Premium |
|---|---|---|
| Individual Life | | |
| Discovery Retirement Optimiser | | |
| Discovery Health plan | | |
| Vitality | | |
| Discovery Retirement Plan | | |
| Discovery Insure | | |
| Other health plan/medical scheme | | |

Note:

- Contributions to other health plans or medical schemes in force at the date of disability will also be covered, subject to maximums set by Discovery Group Risk.
- Details of the health plan or medical scheme, including policy number, membership number and membership certificate, must be provided
- Discovery Group Risk premiums are not included in these premiums.

### Transport Protector

Do you want to make use of this facility?

Yes

No

### Mortgage Protector

Please submit a copy of the home loan statement reflecting the past 12 months' home loan instalments.

Vitality status

### Performance Bonus Protector

Did you receive a performance bonus or incentive?

Yes

No

If "Yes", please submit proof of bonuses received for the past three years.

Vitality status

## Educational history

Please select the highest level of education passed.

I left school before matric

I have a matric certificate or equivalent

I have a technical qualification

I have a diploma

I have a degree

I have a masters or doctorate

Other (please give details below)

Please provide the name and details of the highest level of education obtained.

Please provide the codes of all driver's licences obtained

## Employment history

Please include your full employment history, from most recent to your earliest position

**Employment 1**

| | |
|---|---|
| Date of employment | D D - M M - Y Y Y Y |
| Name of employer | |
| Job title | |
| Job description and duties performed | |
| Date employment ended | D D - M M - Y Y Y Y |
| Salary at date of leaving | R . |
| Reason for leaving | |

**Employment 2**

| | |
|---|---|
| Date of employment | D D - M M - Y Y Y Y |
| Name of employer | |
| Job title | |
| Job description and duties performed | |
| Date employment ended | D D - M M - Y Y Y Y |
| Salary at date of leaving | R . |
| Reason for leaving | |

**Employment 3**

| | |
|---|---|
| Date of employment | D D - M M - Y Y Y Y |
| Name of employer | |
| Job title | |
| Job description and duties performed | |
| Date employment ended | D D - M M - Y Y Y Y |
| Salary at date of leaving | R . |
| Reason for leaving | |

## Current employment

What is your full-time occupation?

On what date did you stop actively performing the duties of your occupation because of your medical condition'? D D - M M - Y Y Y Y

Do you feel that there are any issues in the workplace that have contributed to your absence such as work stressors or relationships with colleagues or managers?

Do you enjoy going to work? Yes No

Do you see yourself working at the organisation in twelve months' time? Please elaborate on your answer. Yes No

What alternative occupations do you consider yourself qualified for?

What other work would you be interested in exploring to earn an income for you and your family, with or without training or rehabilitation?

Have you discussed a return to work plan with your employer? Yes No

Are there any factors affecting your motivation to return to work? Please elaborate below. Yes No

Please list your main duties

Please specify the percentage of time spent on:

Administrative duties % Manual duties % Supervisory duties %

Travel (car, truck,etc) %

What is your current employment status?

Full time Part-time On sick leave On unpaid leave

Laid off or retrenched Dismissed

What is preventing you from performing your own occupation at present?

When do you expect to return to work? This could be your current occupation or an alternate occupation.

## General medical information

| | |
|---|---|
| My medical conditions are | |
| I experience the following symptoms | |
| I take the following treatment | |

Have you submitted a disability/severe illness claim previously? Yes ☐ No ☐

If "Yes", please give details.

What prompted your application for a disability claim?

When did you first notice your symptoms and when did it start to affect your ability to do your job?

Please tick your ability to do the below activities:

| Activity | On my own | With some help | With a lot of help |
|---|---|---|---|
| Washing | ☐ | ☐ | ☐ |
| Dressing | ☐ | ☐ | ☐ |
| Eating | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ |
| Standing | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ |
| Bending | ☐ | ☐ | ☐ |
| Lifting | ☐ | ☐ | ☐ |
| Carrying | ☐ | ☐ | ☐ |
| Driving | ☐ | ☐ | ☐ |
| Catching a bus/train/taxi | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ |

If "Other", please specify

I can carry out the above-listed activities Yes No

How does this impairment limit you from performing any particular part of your main duties?

Have you been hospitalised due to your condition? Yes No

Name of hospital

Hospital number Date of last admission D D - M M - Y Y Y Y

Date of last discharge D D - M M - Y Y Y Y

Please state dates, names and contact details of all doctors, specialists, hospitals or clinics consulted in connection with your condition (please provide hospital or clinic reference numbers).

Have you suffered any complications? Please supply details.

If your condition resulted from an accident, please give a brief description of the circumstances surrounding the accident.

What was the date of the accident? D D - M M - Y Y Y Y

Address of police station where the accident was reported and the case number

## Income details

Have you instituted a similar claim with any other insurance company or through your employer? Yes ☐ No ☐

If "Yes", please provide the company's name and policy number:

Company name

Policy number

If you have claimed or expect to receive any benefit, income or pension for this period, from any other employer, insurance company, pension or provident fund, or from any other source, please specify:

| Source of benefits | Amount | Lump-sum or monthly payments | Date of payment or date when payments will start |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Banking details

- To ensure protection and fast payment, we will only make payments by electronic fund transfer (EFT).
- Payment will only be made to the member or as instructed by the policyholder or employer.
- No payment to a third party will be allowed.
- We will need proof of the account (A cancelled cheque or bank statement with account number and name of account holder serves as proof), this proof cannot be older than three months.

We instruct Discovery Group Risk to pay the benefit by electronic fund transfer (EFT) as detailed below:

Name of account holder

Date of birth D D - M M - Y Y Y Y ID/passport number

Passport expiry date D D - M M - Y Y Y Y

Nationality

Bank name

Branch name

Branch code Account type: Current ☐ Transmission ☐ Savings ☐

Account number

- Please ensure the above account information is correct. Discovery Group Risk will not be held responsible for delays or other damages because of incorrect details being provided.
- If payment is needed to be made to more than one recipient, please supply separate banking details.
- No payments can be made to a non-South African bank.

## Declaration

I confirm that the above information is true and correct, and that no information has been withheld or omitted. I understand fully and agree that the written statements and affidavits given in support of this claim forms part of the claim. I agree that in the event of me withholding any material fact or me giving false information, I may forfeit any and all benefits for this claim.

Signed at (town or city)

Member signature

Date D D - M M - Y Y Y Y

## How to submit complaints

You can submit your complaint to us on the below contact details or to the other mentioned stakeholders if you are still not satisfied with the outcome.

**Discovery Group Risk contact centre**
Telephone: 0860 047 687
Email: Group_Risk_Complaints@discovery.co.za

**The Information Regulator (South Africa)**
JD House, 27 Stiemens Street
Braamfontein, Johannesburg, 2001
P.O Box 31533
Braamfontein, Johannesburg, 2017
Complaints email: POPIAComplaints.IR@justice.gov.za and PAIAComplaints.IR@justice.gov.za
General enquiries email: inforeg@justice.gov.za

**For advice related complaints, you may approach the office of the FAIS Ombud on the following details:**
Kasteel Park Office Park, Orange Building, 2nd Floor,
Cnr of Nossob and Jochemus Street, Erasmuskloof, Pretoria.
Phone: 012 762 5000 / 012 470 9080
Fax: 012 348 3447 / 012 470 9097
Postal Address: P.O. Box 74571, Lynwood Ridge, 0040
Website: faisombud.co.za

**If we have not resolved a complaint to your satisfaction using the contact details above, you may contact the Long-term Insurance Ombud (LTIO) for further recourse:**
Third Floor, Sunclare Building,
21 Dreyer Street,
Claremont,
Cape Town,
7700
021 657 5000 / 0860 103 236
info@ombud.co.za

## Privacy Statement

When you engage with us, you trust us with personal information about yourself, your spouse, your dependants and beneficiaries. We are committed to protecting your right to privacy and will take all reasonable steps to keep your personal information safe and confidential. The purpose of this Privacy Statement is to set out how we collect, use, share, process and secure/store your personal information, in line with the Protection of Personal Information Act (“POPIA”). Although we may change/update this statement at any time, the link below will always be the most updated version that is available on our website.

***Click here*** to view our Privacy Statement.