REF No 202

Claimant: Disability Claim Form

(To be completed by the Claimant)

FOR

SOUTH AFRICAN LOCAL AUTHORITIES PENSION FUND MEMBERS

NOTE: The completed Disability Claim Form and supporting documents (refer to check list) to be forwarded by the Employer via registered post to:

The Soma Initiative (Pty) Ltd, P.O Box 2475, Clareinch, 7740

GLA Death, Family Funeral and Disability: Monthly Income Benefits Underwritten by Prosperity Insurance

IMPORTANT NOTES AND CHECKLIST:

- **This document is to be completed by the claimant, with assistance from the Employer / Trade Union**
- **Attach / include all the documents required by SOMA as per the checklist hereinafter**
- **Please complete ALL questions – if a question is not applicable please mark "N/A" or "Unknown"**
- **Information on this sheet can be filled in by hand or electronically**
- **For any queries please contact the Soma Help Desk on (021) 671 1977**

CHECKLIST DOCUMENTATION REQUIRED BY SOMA		
	Disability Claim Form Ref No 201 – Completed by the Employer	
	Disability Claim Form Ref No 202 - Completed by the Claimant	
	Medical Specialist Examination Form Ref No 203 – Completed by the Claimant's Specialist	
	Consent Form Ref No 204 – Signed by the Claimant	
	Certified copy of the Claimant's Identity Document	
	All available supporting Medical Reports, X-rays, Special Investigations etc.	
	Certified copy of the Member's Marriage Certificate (where applicable)	
	Certified copy of claimants attendance register for the past two years	

1. EMPLOYER DETAILS

Employer Name:	
Address:	
Telephone Number:	
Employer Contact Person:	

2. PERSONAL PARTICULARS

Surname		First names	
Company ref. number		Title	
Date of birth		ID Number	
Marital Status	Single / Married / Widowed / Divorced	Gender	
Residential address		Postal address	

Telephone numbers:			
Work		Code	
Alternate contact number		Code	
Home		Code	
Cell			
Income Tax number			
Name of Medical Aid Fund			
Medical Aid Membership Number			

3. CURRENT OCCUPATION

Job Title			
Commencement date of employment at your current Employer			
Name of Department at which currently employed		Number of month/years	
Commencement date of employment in your current department		Number of month/years	
How long have you been in your current job? (months/years)			
Have you held any other posts at your current Employer? Yes/No			
If Yes, please name the post/job and describe the functions required. Enter periods employed for each job as well.	**Date from**		**Date to**
1.			
2.			
3.			

4. DETAILS OF EDUCATION AND TRAINING

Please give details of your highest level of schooling, as well as post-school education and any training (academic, technical, in-service, etc.). Also include any on-the-job or in-service training received (during the current or any previous employment either at or outside your current employer).

Year Qualified	Institution	Qualification

Considering your training and experience, for what alternative job(s) do you consider yourself eligible within your current department? (Not what jobs are available)

_____

_____

Are any of the above job(s) available in your current department?

_____

_____

Considering your training and experience, for what alternative job(s) do you consider yourself eligible outside your current department (both at your current employer and in the open labour market)?

_____

_____

_____

_____

_____

_____

5. DETAILS OF OCCUPATION

Work history:

Apart from your present job, please supply a history of all previous jobs/work at or outside your current Employer

From	To	Employer and/or Dept Name	Work position/Occupation

Duties and Functions of Current Job:

Please describe your current duties and functions

Describe the physical demands of the job

Describe the mental demands of the job

Describe the tools, equipment and materials used to perform the job

6. <u>DETAILS OF DISABLEMENT</u>

If your illness / injury was caused by an accident or violent means was it a;

Motor vehicle accident	
Accident at work	
Accident at home	
Other	

If "other" please specify _____

_____

_____

Date on which illness / injury occurred _____

Was there an official enquiry? Yes / No

If "Yes" by whom _____

_____

Has any legal action been taken? Yes / No

If "Yes" give details _____

_____

_____

If appropriate give the;

Police station _____

Police case number_____

Describe in your own words the illness/injury that has given rise to this application for disability– specifically the symptoms/impairments that disable you, and <u>not</u> merely the medical diagnosis:

Please state the reasons why you consider yourself disabled and unable to function in your current post:

To the best of your knowledge what has resulted in your current condition? (Please include the specific diagnosis/diagnoses)

7. DETAILS OF MEDICAL CARE

When did you first consult a medical doctor, clinic or hospital in connection with the above?			
Name of Doctor, Clinic or Hospital		Date	
Specialty or Department		Tel. No & Code	
Address			
Details of your usual family/general practitioner, clinic or hospital			
Name of Doctor, Clinic or Hospital		Tel No. & Code	
Address			
Date of last consultation			

Please give the names of Doctors, Specialists, Clinics, Hospital and other Health Care Professionals you have consulted in the past 3 years:

Name of Doctor, Clinic or Hospital	**Specialty or Department**	**Dates(s) consulted**	**Diagnosis**	**Treatment /surgery received**	**Address and tel. no.**

Please give the details of any Hospitalisation in the past 5 years

Name of Hospital	**Reason for admission**	**Date admitted**	**Date discharged**	**Relevant Doctor's Name**	**Address and tel. no.**

8. DETAILS OF THE IMPACT OF YOUR HEALTH CONDITION ON WORK PERFORMANCE

Details of other concurrent or past illnesses/injuries which you feel contributed to your alleged incapacity
List and detail the specific work duties which you are not able to perform

Describe the specific difficulties you are experiencing in performing your duties

Do you think you will be able to return to your present job? Yes/No		Full/part-time	
If not, why not? Please provide detail:			

Detail any alternative jobs (within or outside your current Employer or in self-employment) you have performed since you became ill/injured

Detail any other jobs or income producing activities you may be able to perform in future either with your current Employer or in the open labour market.

9. DETAIL THE IMPACT OF YOUR HEALTH CONDITION ON OTHER FUNCTIONS

Describe the practical implications of your illness/injury on the following activities of daily living:

Mobility (standing, walking, sitting, bending, carrying, etc.)

Self-care (eating, dressing, bathing, etc.)

Home management (domestic chores, gardening, shopping, home maintenance, etc.)
Transport (driving, use of public transport, etc.)

Sport and recreational activities

Other

10. DETAILS OF OTHER INCOME/COMPENSATION

Have you received / are you receiving / do you expect to receive any benefit, salary or income from other sources, such as insurance companies, pension, provident or retirement fund, any state fund, compensation for occupational injuries and diseases, a business venture or any other source? If "Yes" please provide details.

Source	Amount	Date of payment	Expected period of payment

Please Note:

The Scheme reserves the right to obtain a copy of your most recent tax return from the South African Revenue Service

Declaration

I hereby declare and confirm that the answers given by me and the information disclosed in this form are complete in all respects, are both true and correct (whether in my handwriting or not) and that no material information has been withheld nor has any relevant information regarding my physical and/or mental health been omitted, either intentionally or negligently.

Signature or mark of employee		**Date:**	
If not the employee, provide details of the person completing the form on behalf of the employee			
Full Name & Surname			
Relationship to Applicant (family member, colleague, union representative)			
Tel No.		**Code**	
Cell No.			

Signature of witness		**Date**	
Full Name & Surname			
Tel No.		**Code**	
Cell No.			