REF No 205

Disability Appeal Form

(To be completed by the Claimant)

FOR

SOUTH AFRICAN LOCAL AUTHORITIES PENSION FUND MEMBERS

NOTE: The completed Disability Appeal Form and supporting documents (refer to Checklist) to be forwarded to Soma Initiative, P.O Box 2475, Clareinch, 7740

GLA Death, Family Funeral, Disability: Monthly Income and Accidental Hospitalization Benefits administered by Prosperity Management *Africa* (Pty) Ltd

IMPORTANT NOTES AND CHECKLIST:

- **This document is to be completed by the Claimant with the assistance of the Employer HR;**
- **Add the documents required by SOMA as per the Checklist hereinafter;**
- **Please complete ALL questions – if a question is not applicable please mark N/A**
- **Information can be filled in by hand or electronically;**
- **For any queries please contact the Soma Help Desk on (021) 671 1977.**

Your application for Disability Monthly Income Benefits was repudiated (declined) because the medical information in our possession did not confirm that you were rendered Totally and Permanently disabled.
It is your responsibility to therefore provide new medical evidence to support that you are Totally and Permanently vocationally disabled.

CHECKLIST

- **Include all new supporting Medical or other evidence acquired since the repudiation of the initial Disability Application, inclusive of specialist reports and special investigation results to prove Total and Permanent disability.**

EMPLOYER DETAILS

Employer Name	
Address	
Telephone Number	
Employer Contact Person	

PERSONAL DETAILS

Surname		First names	
Pension Ref. No.		Title	
Date of birth		ID Number	
Marital Status		Gender	
Name of Medical Aid Fund		Medical Aid Membership Number	
Residential address		Postal address	

Telephone numbers			
During Office hours		Code	
Alternate contact number		Code	
Home		Code	
Cell			
Date of employment			
Date of initial Disability Application			

APPEAL APPLICATION

Please explain in your own words how your incapacity affects your ability to perform the duties of your own occupation

____

____

____

____

Have your symptoms or condition worsened since your initial application for disability benefits? Yes / No ___________

If yes, please detail this deterioration in your own words

____

____

____

____

INFORMATION AFTER INITIAL APPLICATION FOR DISABILITY INCOME BENEFITS:

State the name and address of doctor(s) and the dates on which you have consulted them **after** your initial application for disability benefits was repudiated (please include all additional new reports) :

____

____

____

____

After your initial application, are you receiving any further medical treatment for your disability?

Yes / No __________ If yes, state nature of treatment including dosages of all drugs:

____

____

____

____

____

____

Has there been any improvement in your condition **after** since your initial Disability Application? Yes / No __________ If yes, please detail the improvement:

____

____

____

____

If you have been hospitalized for your disability **after** your initial application, please state:

Name of Hospital: ____

Name of attending Doctor: ____

Date of Admission: __________________Date of Discharge: ______________________

Are you wholly confined to your home? Yes / No _________

If yes, for how long? ____

If no, briefly describe your daily activities:

____

____

____

____

Did your Employer offer you alternative work, or attempt to adapt your workplace to accommodate your disability? Yes / No __________

If yes, please detail the alternative work and/or the work place adaptations made.

____

____

____

____

____

If no, please explain why not.

____

____

____

____

Please explain in your own words why you feel these changes are not sufficient to enable you to return to work either in your own or an alternate occupation:

____

____

____

____

____

____

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.

I further declare that I am the deponent mentioned above and acknowledge that I know and understand the contents of this document.

____

Signature or Mark of Claimant

SIGNED AND AFFIRMED AT: ____________________________________

On this _________ **day of** _________________________________**20**________