

Claimant: Consent Form

(To be completed by the Claimant)

FOR

SOUTH AFRICAN LOCAL AUTHORITIES PENSION FUND MEMBERS



NOTE: The completed Employee Consent Form and supporting documents (refer to check list) to be posted 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**

Authority

I Identity Number
..... an employee of (hereafter referred to as “the Employer”) hereby authorise any medical practitioner, hospital, institution, clinic, health care provider or any other relevant person that may hold any medical records relating to me and /or any treatment or advice provided to furnish and release to the **South African Local Authorities Pension Fund**, and /or any representatives, agents, consultants, health risk manager or Medical/Disability Advisor/s appointed by the **South African Local Authorities Pension Fund** (hereafter collectively referred to as “the representatives”) any and all details and information, specifically including confidential information, relating to any illness, injury or condition including, without limitation, all clinical records, laboratory results (including blood and other tests), x-rays, records of all prescribed medications and treatments, progress reports and summaries, correspondence between my medical practitioner and any other person who has provided treatment or where I have been a patient or from whom I have received any medical treatment of any nature whatsoever.

I know and understand that by providing this authority I am curtailing my right to privacy and acknowledge and agree that this is necessary and essential for the **South African Local Authorities Pension Fund** and/or the representatives to consider, inter alia, the provision of disability benefits.

This authority is limited to such information as may reasonably be required by the **South African Local Authorities Pension Fund** and/or the representatives for the purpose of considering and evaluating an application for a disability benefit and for no other purpose without my prior written consent.

I hereby also authorise the Employer to disclose and make available to the **South African Local Authorities Pension Fund** and/or the representatives any and all information referred to above as well as any other information that may be in the Employer’s possession, including previous applications for disability benefits, medical reports, job descriptions and specifications and related records. I further authorise the representatives to disclose and make available any of the foregoing information in its possession to the **South African Local Authorities Pension Fund**.

I confirm that a photostatic copy of this authority shall be as effective and valid as the original.

I acknowledge that the **South African Local Authorities Pension Fund** will not consider any application, for disability benefits, as aforesaid in the absence of this written authority.

Consent to Undergo Medical Examination

I acknowledge that for the **South African Local Authorities Pension Fund** to consider and evaluate any application for disability benefits, I may be required to undergo medical and/or psychological evaluation and other tests including, without limiting the generality of the afore-going, blood tests, for the purpose of determining the nature, extent and duration of any incapacity or illness suffered by me.

I further acknowledge that the **South African Local Authorities Pension Fund** or its representatives, may make appointments on my behalf to attend any required medical or other required evaluation as they may determine on reasonable prior notice to me and that, subject to the provision set out below, the costs of any such evaluation shall be the responsibility of the **Prosperity Insurance Company Limited**.

I undertake to present myself for any appointment timeously and with any and all required documentation and information as advised by the **South African Local Authorities Pension Fund** or its representatives and agree that in the event that I neglect or fail to attend any appointment without reasonable prior notice and with acceptable justification to the **South African Local Authorities Pension Fund, and it's representatives**, any costs of the first appointment that may be incurred consequent on my failure to attend will be for my account and will be offset against any subsequent appointments.

Indemnity

I hereby indemnify the **South African Local Authorities Pension Fund** and the representatives, and any directors, agents and employees against any claim of whatever nature which may be made against them as a result of or arising from the furnishing of any information as provided for herein.

Signed aton this theday of20.....

DECLARANT'S SIGNATURE OR MARK

REFUSAL TO SIGN (Please tick)	<input type="checkbox"/>
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Signature of witness 1		Date	
Full Name & Surname:			
Tel No. :		Code	
Cell No. :			

Signature of witness 2		Date	
Full Name & Surname :			
Tel No. :		Code	
Cell No. :			