

Disability Claim Form Classic Range

CLIENT DETAILS

INVESTMENT ACCOUNT NUMBER																					
NAME/S																					
SURNAME																					
IDENTITY/PASSPORT NUMBER																					
DATE OF BIRTH	<table border="1"><tr><td></td><td></td><td>-</td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></tr><tr><td>D</td><td>D</td><td></td><td>M</td><td>M</td><td></td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>			-			-					D	D		M	M		Y	Y	Y	Y
		-			-																
D	D		M	M		Y	Y	Y	Y												
NAME OF MEDICAL SCHEME																					
INCOME TAX NUMBER																					
PERSONAL STATUS	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW/WIDOWER																				
IF MARRIED, PLEASE STATE OCCUPATION OF SPOUSE																					

CLIENT'S PHYSICAL ADDRESS

COMPLEX / UNIT / HOUSE NUMBER					
COMPLEX NAME / ESTATE					
STREET NUMBER					
STREET NAME / FARM NAME / AREA NAME*					
SUBURB / DISTRICT*					
CITY / TOWN*					
COUNTRY*					
	CODE* <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>				

*Compulsory fields

CLIENT'S POSTAL ADDRESS

<input type="checkbox"/> SAME AS PHYSICAL ADDRESS	
PO BOX NUMBER	
POST OFFICE NAME	
POSTAL CODE	
PRIVATE BAG NUMBER	
POST OFFICE NAME	
POSTAL CODE	
POSTNET SUITE NUMBER	
PRIVATE BAG NUMBER	
POST OFFICE NAME	
POSTAL CODE	



SALARY HISTORY

Please provide full details of the member's salary history over the last two years. If the member has worked for the employer for less than two years, please indicate the salary history from the date of appointment.

Date			
Increase amount / percentage			
New salary			
Frequency paid (weekly/monthly/annually)			
Reason for change (annual increase, annual bonus, promotion)			
Estimated amount of additional earnings through overtime, commissions etc.			

INFORMATION RELATING TO YOUR INCOME

STANLIB reserves the rights to call for proof of income and sight of relevant tax forms

WHAT WAS YOUR TAXABLE INCOME FOR THE PAST 12 MONTHS?

R .

COMMISSION EARNED DURING THE PAST 12 MONTHS?

R .

DIRECTOR'S CHARGES FOR THE PAST 12 MONTHS?

R .

HAVE YOU RECEIVED ANY INCOME SINCE DISABLEMENT?

YES

NO

IF "YES", PLEASE STATE INCOME AMOUNT FOR EVERY MONTH SINCE DISABLEMENT

PLEASE PROVIDE DETAILS OF THE SOURCE OF INCOME

HAVE YOU LODGED OR INTEND LODGING A CLAIM FOR PAYMENT OF DISABILITY BENEFITS WITH ANY OTHER PARTY?

YES

NO

NAME OF OTHER PARTY	POLICY NUMBER	DATE OF INCEPTION	ESTIMATED VALUE

ARE YOU CURRENTLY RECEIVING ANY OTHER BENEFITS?

YES

NO

IF YES, PROVIDE MORE DETAILS

INFORMATION RELATING TO IMPAIRMENT

NATURE OF DISABILITY/IMPAIRMENT(S)

INDICATE IF YOUR IMPAIRMENT(S)/DISABILITY IS DUE TO

ACCIDENT/TRAUMA

DISEASE/ILLNESS

DATE OF IMPAIRMENT

- -

D D M M Y Y Y Y



IF THE DISABILITY/IMPAIRMENT IS A RESULT OF AN ACCIDENT, WHEN, WHERE AND HOW DID THE ACCIDENT OCCUR?

Empty text box for accident details.

FULL DETAILS OF INJURIES SUSTAINED

Empty text box for injury details.

NAME OF POLICE STATION

Grid for name of police station.

CASE NUMBER

Grid for case number.

HAVE YOU INSTITUTED A CLAIM FOR BENEFITS AGAINST THE MULTILATERAL MOTOR VEHICLE FUND?

YES checkbox

NO checkbox

IF YES, PLEASE PROVIDE A REFERENCE NUMBER UNDER WHICH THE CLAIM WAS LODGED

Empty text box for claim reference number.

If the disability/impairment is due to illness/disease, please provide the following details

DATE THE ILLNESS WAS FIRST DIAGNOSED

DD - MM - YYYY date grid

Attending doctor/s including specialist/s

NAME

Grid for name of doctor 1

STREET

Grid for street of doctor 1

SUBURB

Grid for suburb of doctor 1

CITY/TOWN

Grid for city/town of doctor 1

COUNTRY

Grid for country of doctor 1

POSTAL CODE

Grid for postal code of doctor 1

TELEPHONE NUMBER

Grid for telephone number of doctor 1

TELEPHONE NUMBER

NAME

Grid for name of doctor 2

STREET

Grid for street of doctor 2

SUBURB

Grid for suburb of doctor 2

CITY/TOWN

Grid for city/town of doctor 2

COUNTRY

Grid for country of doctor 2

POSTAL CODE

Grid for postal code of doctor 2

TELEPHONE NUMBER

Grid for telephone number of doctor 2

TELEPHONE NUMBER

WHAT PRESCRIBED TREATMENT ARE YOU CURRENTLY TAKING/USING?

Empty text box for prescribed treatment.

General practitioner during the last 5 years

NAME

Grid for name of GP

STREET

Grid for street of GP

SUBURB

Grid for suburb of GP



CITY/TOWN																									
COUNTRY																					POSTAL CODE				
TELEPHONE NUMBER			-							TELEPHONE NUMBER			-												
HAVE YOU BEEN CONFINED TO A	<input type="checkbox"/>	HOUSE	<input type="checkbox"/>	BED	<input type="checkbox"/>	HOSPITAL																			
DURATION	<input type="checkbox"/>	DAYS	<input type="checkbox"/>	MONTHS	<input type="checkbox"/>	YEARS																			

History of all medical consultations/treatments over the last 5 years (treatments for colds and flu may be omitted)

DATE	REASONS	TREATMENT	HOSPITAL/DOCTOR	TELEPHONE

DETAILS OF HOSPITALISATION WITHIN THE LAST 2 YEARS

NAME OF HOSPITAL																								
DATE OF ADMISSION	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
	D	D		M	M		Y	Y	Y	Y														
DATE DISCHARGED	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
	D	D		M	M		Y	Y	Y	Y														

Attending doctor/s including specialist/s

NAME																								
SURNAME																								
CONTACT DETAILS																								
EMAIL/FAX NUMBER																								
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	D	D		M	M		Y	Y	Y	Y														

BANKING DETAILS FOR PAYMENTS

Payments to third party bank accounts are not allowed. Payments can only be paid into an account in the name of the client.

BANK																								
BRANCH													BRANCH CODE											
ACCOUNT NUMBER																								
ACCOUNT TYPE	<input type="checkbox"/>	CHEQUE	<input type="checkbox"/>	SAVINGS	<input type="checkbox"/>	TRANSMISSION																		
ACCOUNT HOLDER'S ID NUMBER																								
ACCOUNT HOLDER'S NAME																								



SUPPORTING DOCUMENTATION

Please attach the following supporting documentation with the completed claim form:

- Declaration by Employer to consider Disability Claim and to verify that the information is correct
- Medical Reports completed by the Medical Doctor who is currently treating the Client;
- Declaration by the Medical Specialists who have been treating the Client stating that the Client is disabled and unable to find Employment due to the disability;
- Detailed report from the Specialist treating the Client;
- Hospital reports
- A copy of the Accident Report if the Disability was caused by an accident.

INVESTOR DECLARATION

1. I/We acknowledge that I/We provide consent to STANLIB to collect, process, store, disclose and share my Personal Information for the purpose of servicing my investment.
2. I/We agree to provide all documentation and information requested in this document and further required by law and consent to STANLIB processing my information for the purposes stipulated within the Terms and Conditions.
3. I/We confirm that all information provided herein is true and correct and that I/We have read and understood the contents of this form.
4. I/We acknowledge and accept that the information contained in this form and information about the Account Holder may be provided to SARS. Further, that SARS may also exchange the information with the tax authorities of another country or countries in which the Account Holder may be tax resident.

If the information you have provided in this form changes in future, please submit a new form within 30 days. If you are not the Account Holder please indicate the capacity in which you are signing the form. If signing under a power of attorney please also attach a certified copy of the power of attorney.

SIGNATURE OF CLIENT / AUTHORISED SIGNATORY *	<input type="text"/>	DATE	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y
CAPACITY	<input type="text"/>	SIGNED AT	<input type="text"/>
SIGNATURE OF FINANCIAL ADVISER	<input type="text"/>	DATE	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y
		SIGNED AT	<input type="text"/>

