Liberty Life Botswana (Pty) Limited
Reg.No. 2007/5282
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Disability Claimant's Statement

We are required to share, collect and process your Personal Information (PI). Your PI is collected and processed by our staff, representatives or sub-contractors and we make every effort to protect and secure your PI. You are entitled at any time to request access to the information Liberty Life has collected, processed and shared.

REQUIREMENTS

- Completed SECTION A – Completed by the owner or life assured.
- Completed SECTION B - Medical Statement form completed by the qualified medical practitioner that is treating the life assured for the event that has brought rise to this disability claim. The qualified medical practitioner should complete the form and send it directly back to Liberty Life or the broker.
- Completed SECTION C – Declaration by Employer form to be completed by the employer and sent back to the Broker or Liberty directly for consideration of this disability claim – not applicable if applying under Credit Life.
- Copy of Acceptable form of Identification of life assured.
- Any supporting documentation that will aid us in assessing the claim must be submitted.
- A copy of the Member's payslip for the last completed month of employment .
- Proof of Account (Please refer to page 4 – Payment details for full explanation).
- If applying for benefit under Credit Life please ensure SECTION 6 is completed and supply relevant documentation.

Liberty Life reserves the right to call for additional requirements where deemed necessary.

The contact per for this claim is:

Name

Branch

Contact details Home Work

Mobile Fax

Note: Claims Department will send correspondence and copies only where this information has been supplied. In other circumstances, correspondence will be directed to the owner/ life assured.

Liberty Life's claimants statement (Please tick applicable block)

Benefits claimed ☐ Permanent disability ☐ Temporary disability

SECTION A: CLAIMANTS DETAILS

1. PLAN DETAILS

Surname

First name Gender M F

Identity number Date of birth D D - M M - Y Y Y Y

Name of scheme

Scheme number

Contact details Home Work

Mobile Fax

E-mail address

Residential address

Postal code

Postal address

Postal code

Highest academic, professional or trade qualification

2. PERSONAL DETAILS

Have you ever been insolvent or is there any sequestration hearing proceeding, pending or contemplated? ☐ Yes ☐ No

If "Yes", please provide details:

3. INFORMATION RELATING TO YOUR MEDICAL CONDITION

What is the diagnosis of your condition?

When did this condition start? D D - M M - Y Y Y Y

Indicate if your condition is due to ☐ Accident/Trauma ☐ Disease/Illness

If the condition resulted from "Accident/Trauma", when and where did the this event occur

Police station where accident was reported

Case number

If the condition is due to "Disease/Illness", date diagnosed D D - M M - Y Y Y Y

Details of attending medical practitioners

NAME	TELEPHONE NUMBER	REASON FOR CONSULTATION	DATE OF CONSULTATION

What prescribed treatment are you currently taking?

Contact details of your usual medical practitioner during the last 5 years

4. PARTICULARS OF CURRENT OCCUPATION (ALSO APPLICABLE TO SELF EMPLOYED)

Name Number of years of service

Address

Postal code

Breakdown of your duties

ADMINISTRATIVE	SUPERVISORY	MANUAL	TRAVEL
%	%	%	%

Occupation immediately before your current condition started

Provide an accurate description of the exact duties and nature of your full time occupation (job description)

How long have you been performing this occupation? ☐☐ years

On what date were you last able to undertake any part of the duties of your occupation? D D - M M - Y Y Y Y

On what date do you expect to return to work? D D - M M - Y Y Y Y

Provide details of any hobbies or other occupations

If "Other occupation", describe duties

When do you expect to follow the other occupation ? D D - M M - Y Y Y Y On a ☐ Full time basis ☐ Part time basis

Expected numeration of the other occupation

Details of occupations held in the past

NAME OF EMPLOYER	NATURE OF OCCUPATION	DATE FROM	DATE TO

5. INFORMATION RELATING TO YOUR INCOME (LIBERTY LIFE RESERVES THE RIGHT TO CALL FOR PROOF OF INCOME AND SIGHT OF THE RELEVANT FORMS)

Over the past 12 months please state

Taxable income earned

Commission earned

Directors fees earned

Have you received income since disablement? ☐ Yes ☐ No

If "Yes", please provide income amount for every month since disablement, including amounts, dates and sources of income

Have you claimed or do you intend claiming for payment of disability, dread disease, impairment or any similar benefits with any other insurance companies? ☐ Yes ☐ No

NAME OF INSURANCE COMPANY	POLICY NUMBER	DATE OF CLAIM	ESTIMATED VALUE

Are you currently receiving any other benefits during your disability? ☐ Yes ☐ No

If "Yes", please provide details

6. LOAN DETAILS (TO BE COMPLETED ONLY IF APPLYING UNDER CREDIT LIFE POLICY)

Type of loan agreement

Original loan amount

Monthly instalment

Outstanding balance at date of event

Amount in arrears

Company's minimum liability (claim amount)

Months in arrears

(Please attached a copy of signed loan agreement and copy of last statement.)

7. PAYMENT DETAILS (NOT APPLICABLE FOR CREDIT LIFE)

For your protection payment will only be effected by Electronic Fund Transfer, this will also ensure faster payment. Payment may only be made to the owner. Payment can be made to the bank account which is currently paying the contributions subject to the approval of the owner. Should bank details differ to the account details on record, please provide proof of account i.e. a copy of a cancelled cheque OR copy of current bank statement on a bank letterhead OR a copy of a printout from the bank with a bank stamp.

Name of account holder

Name of bank

Name of branch

Branch code

Account type

Account number

(Excluding credit card.) Liberty Life will not bear any responsibility for delays or other damage due to incorrect details being provided.

8. DECLARATION

I, in my capacity as the life assured, declare and warrant that all statements and answers given are true and complete. I further understand that any misstatement or non-disclosure of information which materially affects the assessment of this claim will entitle Liberty Life to declare this claim null and void.

I agree that the written statements and affidavits of all the qualified medical practitioners who attended or treated the life assured and all other papers submitted in support of this claim, shall constitute and are hereby made a part of this claim, and further agree that the supply of this form, or any other forms supplemental hereto by Liberty Life, shall not constitute any admission by it that there is any assurance in force on the life in question or a waiver of any of its rights or defences in law.

I acknowledge and agree that any benefits payable in respect of this claim shall be forfeited if I, or anyone acting on my behalf or with my knowledge or consent, have knowingly withheld any material fact or submitted any false information in respect of this claim. I further agree that upon payment of the benefits hereby claimed, Liberty Life shall be discharged from all liability in respect of such benefit.

I hereby authorise any medical practitioner, hospital or any other person to furnish to Liberty Life, or its representative any details relating to any illness or injury to the life assured or such other information as may be necessary to consider this claim. I know and understand the confidential nature of medical information. By appending my signatures at the end of this Personal Declaration, I am agreeing that I have given permission to Liberty Life to obtain medical information and evidence from and / or through third parties without it being seen as a breach of my right of privacy and confidentiality. I further agree that any authorised medical personnel or practitioner may release confidential information to Liberty Life or other person acting on their behalf and in such manner or method as Liberty Life may direct.

I indemnify Liberty Life and its directors, agents and employees against any claim of whatever nature which may be made against them as a result of or arising out of the furnishing of such information. Where the conditions of the contract so allow, I irrevocably authorise Liberty Life to deduct any expenses incurred by it in respect of this claim and for which I am liable from the benefits payable under the contract. In the event that a claimant is both the life assured and the owner of the contract AND is incapable of managing his/her own affairs, an appointment of a curator bonis will be required in order for Liberty Life to further assess the claim.

Signed at , _____ this , _____ day of , _____ 20, _____

Signature of owner

Signature of life assured nature

SECTION B: MEDICAL CERTIFICATE FOR DISABILITY

Dear Medical Practitioner

We would appreciate your co-operation in providing the information requested in this form.

Insurance disability has two components i.e. functional impairment and disability. The assessment of functional impairment rests with various medical experts and is aimed at establishing the degree of impairment of normal functions due to medical, psychiatric or traumatic causes after reasonable treatment. It also involves the duration of the impairment, whether it is of a permanent nature or temporary, and if temporary the likely duration and prognosis.

The decision regarding disability is a legal decision taken by the insurance company and is based on details of the claimant, the occupation for which the claimant is insured, the terms and conditions on which the risk was accepted and the contract issued and the medical impairment of the life assured itself. The information requested, is therefore required to assist us in reaching this decision as quickly as possible.

The fee payable is in accordance with the scale agreed by Liberty Life. Please do not hesitate to contact us if you require further information.

Thanking you in anticipation.

Yours faithfully
Liberty Life
Claims Management

Confidentiality notice

This information is intended for the addressee only and may contain confidential and privileged information. If you are not the addressee, the employee or agent thereof you must not take any action based on the information enclosed. If this facsimile is received in error please notify the sender immediately to arrange return at our expense.

1. PATIENT/CLAIMANT'S DETAILS

First name

Identity number

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

Membership number

Occupation (including description of duties)

Qualification

Last day of work D D - M M - Y Y Y Y

2. MEDICAL HISTORY

What were your patient's symptoms?

What is your patient's diagnosis?

Has your patient previously suffered from this medical condition or any related illness? ☐ Yes ☐ No

When was the diagnosis made? D D - M M - Y Y Y Y

Date symptoms started D D - M M - Y Y Y Y

Date first seen by you for this condition D D - M M - Y Y Y Y

Date stopped working D D - M M - Y Y Y Y Date expected to return to work D D - M M - Y Y Y Y

Provide any other comments

Please provide details of any other consultations

CONSULTATION DATE	REASON FOR CONSULTATION	TREATMENT PRESCRIBED	DURATION OF CONDITION

3. FUNCTIONAL ABILITIES

Please comment on the claimant's ability to carry out the specified activities in the table below. (Please mark the appropriate column.)

ACTIVITY	CURRENT LIMITATIONS				EXPECTED FUTURE ABILITY		
	NONE	PARTIAL	IMPOSSIBLE	DANGER TO SELF/OTHERS	IMPROVE	REMAIN CONSTANT	DETERIORATE
Seated/sedentary tasks	☐	☐	☐	☐	☐	☐	☐
Clerical/administrative tasks	☐	☐	☐	☐	☐	☐	☐
Thinking clearly and making decisions	☐	☐	☐	☐	☐	☐	☐
Interacting with others	☐	☐	☐	☐	☐	☐	☐
Walking (non-strenuous) over level ground	☐	☐	☐	☐	☐	☐	☐
Walking (strenuous) over uneven ground	☐	☐	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐	☐	☐
Operating light machinery	☐	☐	☐	☐	☐	☐	☐
Operating heavy machinery	☐	☐	☐	☐	☐	☐	☐
Working with light weights	☐	☐	☐	☐	☐	☐	☐
Driving a light motor vehicle	☐	☐	☐	☐	☐	☐	☐
Driving a heavy motor vehicle	☐	☐	☐	☐	☐	☐	☐
Light manual labour	☐	☐	☐	☐	☐	☐	☐
Use of both arms and legs	☐	☐	☐	☐	☐	☐	☐
Use of fine co-ordination	☐	☐	☐	☐	☐	☐	☐
Work in cramped conditions	☐	☐	☐	☐	☐	☐	☐
Work in dusty environment	☐	☐	☐	☐	☐	☐	☐
Work in fume environment	☐	☐	☐	☐	☐	☐	☐

General comments, which may clarify the responses in the table above. If improvement is expected, please indicate the time period in which that improvement is anticipated.

If period off work is longer than usually expected for impairment, please provide details:

4. TREATMENT AND REHABILITATION

Current medication regime. Please specify all medications and dosages:

Other treatment the claimant has received or is currently receiving (e.g. physiotherapy, occupational therapy, psychotherapy):

Planned future treatment, including surgery:

Your recommendations regarding rehabilitation (if applicable):

Please attach copies of any correspondence received from any practitioners, specialists or hospitals in respect of the claimant.

5. MEDICAL PRACTITIONER'S DETAILS

Name

Practice number

Contact details Home Work

Mobile Fax

E-mail

Address

Postal code

Qualifications

6. PAYMENT DETAILS

Please supply the following details in order for us to pay your account and please attach a statement of account .

Name of account holder

Name of bank

Name of branch

Branch code

Account type

Account number

7. DECLARATION

I declare that to the best of my belief and knowledge, the information contained in this report is true, accurate and complete and that any information that could influence a decision regarding this claim, has not been withheld.

Signed at , _____ this , _____ day of , _____ 20, _____

Signature of medical practitioner

SECTION C: EMPLOYERS DECLARATION

If self-employed, this section must be completed by an auditor/bookkeeper or relevant third party.

1. EMPLOYMENT DETAILS

Name of company

Contact details Work

Fax

E-mail address

Name of scheme

Scheme number

Name of employee

Identity/Passport number

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

Employee number

Date of employment D D - M M - Y Y Y Y

On what date was the employee last able to undertake any part of his occupational duties at work? D D - M M - Y Y Y Y

On what date was the employee's service terminated? D D - M M - Y Y Y Y

Reason for termination (e.g. ill health retirement/retrenched/boarded etc.). If the reason for termination relates to boarding, please attach the relevant documents.

Until what date has any remuneration been paid? D D - M M - Y Y Y Y

What was the employee status? Full-time Part-time

Details of remuneration for past 12 months

What was the employee's designated occupation?

What was the exact nature of the employee's work? (Please provide full details or attach a copy of job description.)

Anticipated date that the employee will return to work (if applicable) D D - M M - Y Y Y Y

Has any consideration been given to the extent to which the employee's work circumstances or duties might be adapted to accommodate the employee's disability needs? Yes No

If 'No", please provide details

Has any consideration been given to the availability of any other suitable work? ☐ Yes ☐ No

If 'No", please provide details

In the event of being self-employed, please state if business is to continue. ☐ Yes ☐ No

If 'No", please provide details

2. OTHER INSURANCES

Have you been approached by any other insurance companies for information relating to the employee's current state of disability. If "Yes", please provide details below: ☐ Yes ☐ No

Name of company

Telephone number Fax

Mobile Fax

3. TAX DETAILS

Employee's tax number

Tax office last tax return rendered to

Tax/registration number if self-employed/partnership/cc/company

4. DECLARATION

Full name

Position/Relationship

Company

Telephone number

Address

Postal code

I hereby declare that I am the person designated and authorised by the above-mentioned company to complete and attest to this form and further confirm that all particulars provided hereto are to the best of my belief and knowledge both true and correct. I confirm that no material information, which is relevant to the assessment of this claim has been withheld, concealed or misstated. (In the event of this form being completed by an auditor or an accountant details of their practice numbers must be provided.)

Signed at , _____ this , _____ day of , _____ 20, _____

Signature of employer

COMPANY STAMP