CAPITAL ALLIANCE LIFE LIMITED
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CAPITAL ALLIANCE

Urgent notification of a potential disability or death claim fax transmission

Date _____ Fax (011) 224-1492

To Investec Employee Benefits

☐ Disability claims department

☐ Administration department (for death claims)

From

Name _____

Title _____

Telephone number (code) _____

Type of benefit

Income Security ☐ Managed Disability ☐ Healthbridge ☐ Capital Disability ☐ Death ☐

Other ☐ Please specify _____

Scheme name _____ Scheme number _____

Full name of member _____ Member number _____

Date of birth D D M M Y Y Y Y Occupation _____

Last day actively at work _____

Condition being claimed for/cause of death _____

_____

Attending doctor's name _____

Telephone number (code) _____

Fax number (code) _____

Email address _____

Guidelines on when to notify Capital Alliance of a potential claim. Please mark appropriate box with an X.

☐ Member has been absent from work for a continuous period of three weeks (unless on authorised leave).

☐ Member's job description has changed to allow him to have reduced duties due to a medical condition.

☐ Member's expected productivity has reduced to 50% or less due to medical reasons for a continuous period of three months.

☐ Member's own occupation is changed due to a medical condition.

☐ Member is regularly off work for one to two days per week for a period of two months.

☐ Member is hospitalised due to a dread disease incident/condition.

☐ A dread disease incident/condition is diagnosed.

☐ On the death of a member.

☐ Other: Please specify. _____

Signature _____ Company stamp

The employer/administrator hereby acknowledges that it is fully acquainted with the rules/policy provisions of the scheme in respect of which this notification of a potential claim is submitted. The employer/administrator further acknowledges that the completion and submission of this notification does not constitute the submission of a claim in terms of the scheme rules/policy provisions and that in the event of a claim arising, the employer/administrator is required to timeously complete and submit all claim documentation as required by the scheme rules and as requested by Investec Employee Benefits Limited ("Investec"). In the event that the requisite claim documentation is not so completed and submitted, or in the event that the claim is properly submitted, but does not comply with the requirements of the scheme rules/policy provisions, the employer/administrator acknowledges that Investec will be entitled to repudiate the claim and the employer/administrator hereby absolves Investec of any liability in respect of any legal action being instituted by the claimant or any other party as a result of the employer's/administrator's failure to complete and submit the claim documentation in terms of the scheme rules/policy provisions or in terms of the written instructions of Investec.

Notification of potential Income Security / Managed Disability / Healthbridge / Capital Disability / Death claim by the employer to Capital Alliance

The purpose of this document is to provide you, the employer, with relevant information on the importance of early notification of a death or potential disability claim to Capital Alliance. Timeous notification will greatly reduce the chance of a claim not being admitted due to late submission.

The purpose of the notification is to:
- Enable Capital Alliance to comment on the present treatment (for disability claims).
- Allow Capital Alliance to advise on possible rehabilitation (for disability claims).
- Allow the actuary to correctly rate the scheme.

Disability benefits

As soon as a member of an **Income Security benefit scheme, Managed Disability benefit scheme, Healthbridge benefit scheme, or Capital Disability scheme** contracts an illness or sustains an injury, the employer must submit written notification to Capital Alliance detailing the claimant's name, date of incident, nature of disablement, last working day and the member's occupation.

Guidelines of when to notify Capital Alliance of a potential claim can be found overleaf.

The maximum time period for notification of disability claims are as follows:

Income Security benefits
(also known as Permanent Health Insurance, Income Security Plan and Total Temporary Disability).
Within three months of the expiry of the waiting period. The waiting period commences on the day that the illness or injury was contracted.

Waiting period is a period of time chosen by the employer at the commencement of the scheme, during which he pays his employee his salary until the scheme starts paying the benefit. The waiting period can be considered as self-insurance by the employer.

Managed Disability benefits
Within four weeks of contracting the injury or illness.

Healthbridge benefits
(also known as Dread disease)
Within three months of the occurrence of the dread disease.

Capital Disability benefits
(also known as Lump Sum Disability and Total Permanent Disability)
Within nine months of contracting the injury or illness.

Death benefits

As soon as a member of a group life scheme (death benefit scheme) dies, the employer must submit written notification detailing the deceased's name, date of death and cause of death.

The maximum time period for notification of a death claim is six months.

General

The notification periods serve as Capital Alliance practice and are less onerous than its official rules and policies. Should there, however, be any policy provisions which are less onerous than these notification periods, the scheme policy will apply in the event of a dispute.

Failure to comply with the notification period will result in the claim being repudiated due to late submission.

In addition to the notification periods, the employer must bear in mind that a maximum period of 12 months from the date of disability/death is permitted to submit the full claims package. Any additional documentation must be submitted within 60 days.

Failure to comply with the above submission of evidence periods, will result in the file being closed and no further evidence being considered for assessment purposes.

Please, contact your broker or Capital Alliance advisor shortly after the death or contracting of the injury or illness to obtain full claims documentation. The documentation should be completed and sent to Capital Alliance to enable it to assess the claim on current evidence and to reach a decision timeously.

This information sets out Capital Alliance policy regarding the requirements for the notification of potential claims. Should you have any additional queries, please contact any of the following people:

Service managers

Johannesburg

• Disability claims Andre Joubert	:	(011) 224-1451	e-mail ajoubert@capitalalliance.co.za
• Death claims Vinesh Chetty	:	(011) 224-1517	e-mail vchetty@capitalalliance.co.za

Cape Town

• Disability claims Christine Jacob	:	(021) 416-1558	e-mail cjacob@capitalalliance.co.za
• Death claims Frank Krieger	:	(021) 416-1561	e-mail fkrieger@capitalalliance.co.za

Head of disability claims and underwriting department (Johannesburg and Cape Town)

Joe Peters	:	(011) 224-1495	e-mail jpeters@capitalalliance.co.za

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An authorised financial services provider

CAPITAL ALLIANCE
Group Risk

Confidential medical report by attending physician

Section B

Tick where applicable	✓	To be completed by the attending physician	Please use a black pen and block letters

Please note: If there is not enough space provided on this form, please continue on a separate sheet of paper.

Dear Claimant

Carefully read the information in the table below before having the disability claims package completed by your physician. You are required to pay the physician for completing the medical report/s.

Capital Alliance would prefer all medical reports to be completed by the attending specialist. In cases where a specialist is not consulted, a report from the attending general practitioner will be accepted. It is then more likely that additional medical reports will be requested.

Guideline of which medical practitioner should complete the medical report/s for your condition

HIV / AIDS	Confidential medical report by **attending general practitioner,** CD4 count and HIV test results
Alzheimer's disease	Confidential medical report by **attending neuropsychologist,** including copies of all tests and reports done
Arthritis, including rheumatoid arthritis	Confidential medical report by **attending rheumatologist,** including copies of all tests and reports done
Backache or any other musculoskeletal disorder such as rotator cuff syndrome	Confidential medical report by **attending orthopaedic surgeon,** including copies of all tests and reports done, especially X-ray reports
Blindness	Confidential medical report by **attending ophthalmologist,** including copies of all tests and reports done, especially visual acuity readings
Cancer	Confidential medical report by **attending oncologist,** including copies of all tests and reports done, especially biopsy tests / histology reports
Cardiac conditions, such as myocardial infarction (heart attack)	Confidential medical report by **attending cardiologist,** including copies of all tests and reports done, especially ejection fraction
Chronic fatigue syndrome	Confidential medical report by **attending specialist,** including copies of all tests and reports done
Cirrhosis of the liver	Confidential medical report by **attending specialist,** including copies of all tests and reports done
Deafness	Confidential medical report by **attending ENT specialist,** including copies of all tests and reports done, especially hearing test results
Diabetes mellitus	Confidential medical report by **attending specialist,** including copies of all tests and reports done, especially most recent HbA1c
Epilepsy	Confidential medical report by **attending neurologist,** including copies of all tests and reports done, especially CAT scans and EEG results
Multiple sclerosis	Confidential medical reports by **attending neurologist,** including copies of all tests and reports done
Paraplegia	Confidential medical report by **attending orthopaedic surgeon / neurosurgeon / neurologist,** including copies of all tests and reports done
Parkinson's disease	Confidential medical report by **attending neurologist / physician,** including copies of all tests and reports done
Psychiatric conditions	Confidential medical report by **attending psychiatrist,** including copies of all tests and reports done and details of treatment regimen
Renal failure or other related conditions	Confidential medical report by **attending nephrologist,** including copies of all tests and reports done, especially renal function tests
All respiratory conditions, such as asthma, emphysema and chronic obstructive airways disease	Confidential medical report by **attending pulmonologist,** including copies of all tests and reports done, especially lung function tests and X-ray reports
Skin conditions	Confidential medical report by **attending dermatologist,** including copies of all tests and reports done
Stroke (cerebrovascular accident)	Confidential medical report by **attending neurologist,** including copies of all tests and reports done, expecially CAT scans
Tuberculosis	Confidential medical report by **attending general practitioner,** including copies of all tests and reports done, especially X-ray reports and sputum test results
Trauma or accident	Confidential medical report by **attending surgeon,** including copies of all tests and reports done

In the event that your condition is not mentioned above, please contact Capital Alliance disability claims assessor for clarification on who should complete your medical report.

Dear Doctor

Capital Alliance has received an application for a disability claim for this member and would appreciate your completing this confidential medical report. It is essential that you complete this form as fully as possible to prevent any unnecessary delays.

Please note:
- **The cost of completing this medical report must be borne by the claimant.**
- **If you have any reports of previous investigations to substantiate the diagnosis, please supply copies.**
- **The request for completion of this form in no way constitutes an admission of liability by Capital Alliance.**
- **If the claimant is only consulting a general practitioner, Capital Alliance suggests he consults a specialist at his/her nearest provincial hospital for completion of the forms where reports are to be completed by a specialist.**

Purpose: To assess the claimant's impairment (medical assessment), and to ascertain:
- change in functional capacity due to illness or injury
- diagnosis
- optimal medical treatment

2. History of impairment

2.1 What is the claimant's Height _____ cm Weight _____ kg

2.2 When did the claimant first consult you? D D M M Y Y Y Y

2.3 On what date did the first symptoms of the condition claimed for appear? D D M M Y Y Y Y

2.4 If you are still attending to the claimant, when was the last consultation? D D M M Y Y Y Y

2.5 Please complete the schedule below

Date	Reason for consultation	Diagnosis	Treatment	Result / prognosis

2.6 Have clinical investigations been performed to determine the condition? Yes ☐ No ☐

If "Yes", comment on the results of all tests/examinations performed to confirm diagnosis (please include copies)

_____

_____

2.7 (a) How has the claimant's condition been treated over the past 12 months? (Discuss treatment regimen prescribed)

Date	Treatment (medication and dosage)	Outcome

2.8 (a) Do you know of any other factors (eg. previous illness or injury, hazardous pastimes or pursuits, habits or self inflicted injuries) that may have contributed in any way to the claimant's impairment? Yes ☐ No ☐

(b) If "Yes", please comment fully.

_____

_____

2.9 (a) In your opinion, when will the claimant be able to go back to work?

Part-time Date D D M M Y Y Y Y Duties _____

Full-time Date D D M M Y Y Y Y Duties _____

(b) If the claimant has already recovered and returned to work, please give the date of his/her return to work. D D M M Y Y Y Y

2.10 Please provide any additional information which you feel will assist Capital Alliance in the assessment of this claim (if there is not enough space provided on this form, please continue on a separate sheet).

- **Have you included copies of all tests and reports?** Yes ☐ No ☐

Additional comments:

3. Details of medical attendant

Doctor's name and address (please print) _____

Telephone number (code) _____ Fax number (code) _____

Cellular number _____ Practice number _____

Email address _____ Date D D M M Y Y Y Y

Qualifications _____

I declare and warrant that all information provided by me in this confidential medical report is complete and true. I accept full responsibility for any inaccuracies or omissions contained in this confidential medical report and I understand that the insurer may bring criminal or civil charges against me in the event that any such inaccuracies or omissions are discovered by the insurer.

Doctor's signature _____

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CAPITAL ALLIANCE

Claim for a disability benefit

Section A

I, _____ (full names of claimant), hereby declare that I am the person assured under the scheme mentioned below. All the particulars given, whether in my handwriting or not, are to the best of my knowledge, true and complete. I accept full responsibility for any inaccuracies or omissions contained in this personal statement and I understand that the insurer may bring criminal or civil charges against me in the event that any such inaccuracies or omissions are discovered by the insurer.

I accept that I am hereby curtailing my right to privacy, but to facilitate the assessment of the risks, and the consideration of any claim for benefits, under a policy related to this or any other proposal for insurance made by me, or in respect of me as life assured, I irrevocably authorise Capital Alliance:

(a) to obtain from any person, whom I hereby so authorise and request to give any information which Capital Alliance deems necessary, and

(b) to share with other insurers that information and any information contained in this proposal or in any related policy or other document, either directly or through a data base operated by or for insurers as a group, at any time (even after my death) and in such detailed abbreviated code form as may from time to time be decided by Capital Alliance or by the operators of such data base.

Please note: The request for completion of the form in no way constitutes an admission of liability by Capital Alliance.

Claimant's personal statement — Part 1

Tick where applicable ✓ | To be completed by the claimant | Please use a black pen and block letters

Please note: If there is not enough space provided on the form, please continue on a separate sheet of paper.

1. Claimant's personal details

Surname _____ First names _____

Member number _____ Date of birth D D M M Y Y Y Y

Identity number | | | | | | | | | | | | | |

NB: please enclose a certified copy of your identity document

Scheme name _____ Scheme number _____

Details of driver's licence _____

Residential address _____

_____ Postal code | | | | |

Postal address _____

_____ Postal code | | | | |

Telephone number (work) (code) _____ Telephone number (home) (code) _____

Fax number (code) _____ Cellular _____

Email _____ Gender Male ☐ Female ☐

Income tax office _____ Income tax number _____

2. Details of occupation

2.1 Date when you started working for your current employer D D M M Y Y Y Y

2.2 Date when you started your current job D D M M Y Y Y Y

2.3 Date when you were last actively able to do this job D D M M Y Y Y Y

2.4 Position held _____

2.5 Please list your main duties.

_____

_____

2. Details of occupation (continued)

2.6 Apart from the above job, please supply a brief employment history, including previous positions held.

Dates From	To	Company	Position held	Type of work done (e.g. welding)

2.7 Have you been able to perform any part of your main duties or another job since you first became disabled? Yes ☐ No ☐

If "Yes", please give details, including dates, job description and remuneration.

2.8 What was the highest level of schooling that you achieved?

Standard/grade	Year

2.9 Please supply details of formal training and any courses which you have attended.

Dates From	To	Name of employer, college or institution	Qualifications obtained	Brief description of course content

3. Details regarding impairment

3.1 List of complaints

3.2 When were these symptoms first noted?

3.3 How has this impairment limited you from performing any particular part of your main duties?

3.4 Please print the name, address and telephone number of your family doctor or the doctor who is currently attending to you.

3.5 Please supply details of all doctors, specialists and hospitals attended during the last five years (quote hospital number where applicable).

Dates From	To	Hospital or doctor	Address and telephone number	Patient number

4. Particulars regarding income

If you receive, or expect to receive, any lump sum or periodic payment or any other benefit as a result of your impairment from any employer, insurance company, pension fund, state fund, compensation for occupational injuries and disease act, or any other source, please give details.

Source of benefit (state name of company and your reference number)	Type of benefit (e.g. insurance, lump sum)	Amount

Signature of claimant _____ Date D D M M Y Y Y Y

Employer's statement Part 2

Tick where applicable ✓ To be completed by the employer Please use a black pen and block letters

Please note: If there is not enough space provided on the form, please continue on a separate sheet of paper.

1. Details of employer

1.1 (a) Name of employer _____

(b) Type of business _____

(c) Employer's address _____

_____ Postal code

(d) Contact person at employer _____

(e) Direct telephone number of contact person (code) _____

(f) Date claimant joined service D D M M Y Y Y Y

(g) Date claimant joined scheme D D M M Y Y Y Y

(h) Monthly pensionable income _____

(i) Month of last contribution D D M M Y Y Y Y
(Please include a copy of last payslip)

1.2 Please supply full details of the claimant's sick leave for the past two years, including copies of medical certificates for any absence exceeding two days. Also indicate days on which the claimant left work early (if available).

Dates (inclusive) From	To	Illness or injury	Working days absent

NB: Please include any details available regarding the claimant's illness/injury.

1.3 When were the symptoms first noted? _____

2. Details regarding the claimant's occupation

2.1 Position held by the claimant _____

2.2 When was the claimant last able to do his own occupation? D D M M Y Y Y Y

2.3 What was the claimant's job category? (Please mark the most applicable)

- ☐ Managerial
- ☐ Supervisory
- ☐ Clerical
- ☐ Other _____
- ☐ Machine operator (e.g. driving or using a machine to perform a task)
- ☐ Light manual labour (e.g. physically packing or sorting)
- ☐ Heavy manual labour (e.g. physically digging or loading)

2. Details regarding the claimant's occupation (continued)

2.4 Summary of main duties (a) _____

(b) _____

(c) _____

2.5 Please describe the minimum physical abilities that a healthy individual requires to do this job (e.g. percentages, kilograms, metres, hours, numbers (how much), bags, sacks (what)).

Strength		How much?	What?
Lift	– kilograms		
Carry	– kilograms / metres		
Push	– kilograms / metres		
Pull	– kilograms / metres		
Hold	– kilograms / metres		
Endurance		How much?	What or where?
Climb	– metres		
Stoop	– percentage of day		
Stand	– percentage of day		
Sit	– percentage of day		
Walk	– smooth terrain	(metres per day)	
Walk	– uneven terrain	(metres per day)	
Accuracy		How much?	What?
Fine precise movement			
Control of tools			

2.6 (a) Please describe the minimum mental abilities that a healthy individual requires to do this job (e.g. describe the tasks requiring mental activity or attach examples).

	Very often	Often	Seldom
Literacy	☐	☐	☐
Numeracy	☐	☐	☐
Memory	☐	☐	☐
Problem solving	☐	☐	☐
Decision making	☐	☐	☐
Specialised knowledge	☐	☐	☐

(b) Summary: In view of the claimant's current medical condition, please describe the mental effort it takes to do this job (e.g. memorising, calculating etc.).

_____

_____

2.7 Please describe the minimum communication skills that a healthy individual requires to do this job (e.g. describe the aspects requiring communication).

	Very often	Often	Seldom
Speaking	☐	☐	☐
Writing	☐	☐	☐
Listening	☐	☐	☐
Reading	☐	☐	☐
Public speaking	☐	☐	☐

2. Details regarding the claimant's occupation (continued)

2.8 How often does the claimant work in the following conditions?

	Very often	Often	Seldom
Dust	☐	☐	☐
Vibration	☐	☐	☐
Noise	☐	☐	☐
Fumes	☐	☐	☐
Heat	☐	☐	☐
Cold	☐	☐	☐

2.9 How much of the claimant's time is spent in the following conditions?

	Percentage / hours
Outdoors	
Indoors	
Height	
Depth	
Wet areas	
Dry areas	

2.10 What are the standard working hours per day? _____

2.11 Have any attempts been made to adapt the claimant's work environment or duties to accommodate his/her condition? Yes ☐ No ☐

If "Yes", please provide full details.

_____

_____

2.12 Has any attempt been made to accommodate the claimant in an alternative position? Yes ☐ No ☐

If "Yes", please provide full details.

_____

_____

2.13 Has the claimant partially or fully recovered, or is the claimant expected to partially or fully recover? Yes ☐ No ☐

If "Yes", when did or when is the claimant expected to return to work? D D M M Y Y Y Y

3. Payment instructions

In terms of the policy, payment is always made directly to the employer. If, as a result of special circumstances, payment is to be made directly to the claimant, please provide a motivation, advising the reason for this.

3.1 Payment to be made directly to: Company/fund/employer ☐ Claimant ☐

3.2 Name of the account holder _____

Postal address of account holder _____ Postal code ☐☐☐☐

Name of banking institution _____ Account number _____

Branch name _____ Branch code _____

3.3 Who is the waiver of premium benefit payment to be made to? Scheme ☐ Company ☐ Insurer ☐

3.4 Name of the account holder _____

Postal address of account holder _____ Postal code ☐☐☐☐

Name of banking institution _____ Account number _____

Branch name _____ Branch code _____

It is hereby declared that, to the best of our knowledge, the particulars above are true and complete.

3. Payment instructions (continued)

Company stamp

Signature _____

Name _____

Position held _____

Date D D M M Y Y Y Y

Direct telephone number (for enquiries) (code) _____

Fax number (code) _____

Cellular number _____

Email address _____