|  |  |  |
| --- | --- | --- |
|  | **Contact details for returning claim forms:** |  |
|  | Fax: | 0860 065 437 |
|  | Postal address (originals): | PO Box 149175 |
|  |  | East End |
|  |  | 4018 |
|  | Email: | [claims@nedbankinsurance.co.za](mailto:claims@nedbankinsurance.co.za) |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DETAILS OF CLAIMANT** | | | | | | | |  | | |
| Policy number | |  | | | | | | | | |
| Claimant’s name | | |  | | | | | | | |
| Date of birth |  | | | | | ID/Passport number | | |  | |
| Date on which employment commenced | | | | |  | | Normal monthly salary at time of disability | | |  |
| Job title/Occupation | | | |  | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DETAILS OF EMPLOYER** | | | | |  | | |
| Employer (company) name | |  | | | | | |
| Name and designation of person completing this form | | |  | | | | |
| Address of employer |  | | | | | | |
|  |  | | | | | Postcode |  |
| Tel (w) |  | | Tel (h) |  | | Cell |  |
| Email |  | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DETAILS OF OCCUPATION** | | | | |  | | |
|  | Please provide specific details of all duties performed by the employee. Please attach a copy of his/her job description | | | | | | |
|  | When was the claimant last able to perform his/her duties? | |  | | | | |
|  |  | | | | | | |
|  |  | | | | | | |
|  | Please indicate if the claimant is performing an alternate occupation or working reduced hours. | | | | |  | |
|  | Please confirm the claimant’s work history with your company. | | |  | | | |
|  |  | | | | | | |
|  |  | | | | | | |
|  | What percentage of normal working hours was spent on the following: | | | | | | |
|  | Commercial duties, i.e. personally buying or selling: |  | | | | | % |
|  |  | | | | | | |
|  |  | | | | | | |

**[CHECK: Refer 1(b) on page 2 of Income Protection Plan Claim Form.]**

|  |  |
| --- | --- |
|  | What duties is the employee currently able to attend to? |
|  |  |
|  |  |
|  |  |
|  | Have any attempts been made to redeploy the employee? If so, please provide details: |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
|  | Please provide details of all medical attention received/sick leave taken by the employee in the past 24 months: |

|  |  |  |
| --- | --- | --- |
| Illness or injury | Name of doctor consulted | Dates absent |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**DECLARATION BY EMPLOYER**

I hereby declare that the above information is true and correct, and that no information has been withheld or omitted.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | | | | |
| Signed at |  | on |  | / |  | / |  |
|  | *(place)* |  | *(day)* | | *(month)* | | *(year)* |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| *(Name in block letters)* |  | *(Designation)* |

|  |  |
| --- | --- |
|  |  |
| *(Signature)* |  |