CONFIDENTIAL MEDICAL REPORT

In respect of a Disability Claim

Dear Doctor
This report is in respect of a disability claim that has been submitted by this patient. Please do not under any circumstances show the claimant the report with out first cosulting with the fund. The report should be faxed to 021 686 5770 and a hard copy must be posted to P O Box 291248, MELVILLE, 2109. Please retain a copy for your records. Thank you for your assistance in this matter.

1. Medical Practitioners Details

Name:……Qualifications/Specialty……

Work postal address: ……

Telephone number ( ) ……Fax number ( ) ……

2. Claimant's Details

Full name: ……

Identity number: ……

Industry number: ……

Company number:……

3. Consultation History

Date of your first ever consultation with Claimant: ……

Date of your first consultation with regards to the current symptomatology:……

Date of your last consultation with the claimant:……

4. Medical References

Please give the details and any other Practitioners, Specialists or Hospitals to whom the Claimant has been referred. Please include copies of all available Specialist reports.

Name of Practitioner/Hospital			
Specialty			
Postal address			
Complaints referred for			

5. Medical History

Please give a full history, including the following:

- Symptoms and diagnoses
- Dates of any diagnoses
- Clinical details indicating severity and permanence
- Relevant test results (e.g. CD4 count, HIV result, lung function readings, X-ray or scan results)
- Treatment and response
- Comments on compliance

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Current major complaint(s):

……

……

6. Results of most recent examination

Date of Examination:……
Please give full clinical details as at that examination, including height, weight and blood pressure readings. Please include details of any limitations evident at that examination (e.g. joint limitations, visual acuity)

……

……

……

7. Prognosis

What are the chances of recovery (good/fair/poor/nil)? ……
Are any residual problems likely? ***Please specify***

……

……

8. FUNCTIONAL ABILITIES

Please comment on the member's ability to carry out the specified activities in the table below:

Activity	**Current limitations**				**Expected future ability**		
	No limitations	Partial limitations	Impossible	Danger to self or others	Improve	Remain constant	Deteriorate
Seated/sedentary tasks							
Clerical/administrative tasks							
Thinking clearly & making decisions							
Interacting with others							
Supervising other							
Walking (non-strenuous) over level ground							
Walking (strenuous) over uneven ground							
Climbing							
Kneeling							
Standing							
Bending							
Operating light machinery							
Operating heavy machinery							
Working with heavy weights							
Working with light weights							
Driving a light motor vehicle							
Light manual labour							
Heavy manual labour							
Use both hands							
Use of fine coordination							
Work in cramped conditions							
Work in dusty environments							
Work in a fume environment							

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

……

……

……

9. 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 Practitioners, Specialists or Hospitals in respect of the claimant.

DECLARATION

I hereby declare that I have personally examined ad attended to the claimant and that the content of this report are true and correct.

....

SIGNED **DATE**

EMPLOYER'S DECLARATION

In respect of a disability claim

This document is central to the assessment of this disability claim. It is to be completed by a manager or supervisor appointed by Municipality. As the claimant's manager, we require your account of the history surrounding this claim. Please ensure that all questions are answered.

1. Employer Details:

Name of employer:……

Participation date:……

Address:……..

Telephone number:( )…… Fax number: ( )……

2. Member Details:

Full Name:……..

Date of Birth:……Identity Number:……

Employee number:……..

Date member entered the fund: ……

Date of employment commenced:……

Last active day at work, attending to all normal duties: ……

Was the member in full-time and normal employment on the last day at work? ……..

If not, please give details:……

Date the member returned to work (if he/she has returned post disability)……

2.1 Days absent from work in the last two years

Dates from/to	Number of working days absent	Type of leave taken(annual/sick/unpaid etc)	Reason

2.2 Employment history

Please indicate the member's full employment history at his/her current employer, from the most recent to the earliest position held.

	Most Recent	Previous	Earlier position
Date started			
Job title			
Educational qualifications required for that position			
Experience required for that position			
Broad description of work done			
Date ceased			
Salary at date of leaving			

Which aspects of his/her most recent job is the member unable to do?
……
……
……..

If the member was subject to any particular pressure, either at work or outside work, please comment on these:……..

……

……

2.3 Salary history

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

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

3. Attempts to accommodate the member

What efforts have you made to adapt the member's work environment or duties to accommodate his/her impairment(s)? ……

……

……

What efforts have you made to accommodate the member in an alternative position?……

……

……

4. Other compensation for disability

Please list all sources (of which you are aware) from which the member may receive compensation as a result of disability.

	Workmen's compensation	Pension or Provident fund	Other
Amount of benefit			
How payable? (Monthly/lump sum)			
Date on which the benefit is or becomes payable			
Length of time the benefit is payable for			
Name of insurer/fund and policy number(s) (if applicable)			

Please attach the following:

- Pay slip for the month of disability.
- Certified copy of original identity document.
- Fully completed job description form.
- Sick leave records covering the past two years, with copies of any sick leave certificates.

5. Declaration

I hereby declare and warrant that the above answers are true and correct, and that no material information has been withheld or omitted.

Name of signatory: …….

Designation:……

Signature:……

Date:……

EMPLOYEE'S DECLARATION

In respect of a disability claim

This document is to be completed and signed by the member wishing to apply for disability benefits. The declaration will be used to assess your claim. Please ensure that all questions are answered, and that the information is complete and accurate. Any misstatement may be used as the basis for the claim not to be admitted

1. Employer details

Name of employer:……

Participation date:……

Address:……..

Telephone number:( )…… Fax number: ( )……

Contact Person: ……..

2. Personal Details:

Full Name:……

Identity Number:……Date of Birth:……

Gender…… Entry date: ……..

Residential Address:……..

……

Postal Address:……

Home / Cell Number: ( )……Work Number:……..

Income tax number:……Income Tax Office:…….

Medical aid scheme: ……Medical aid no: ……

3. Education Details:

3.1. Name of last school attended:……

3.2. Highest Standard Passed: Passed:……

3.3. Name(s) of universities, colleges or technikons

attended:……..

……..

3.4. Degrees and/or certificates obtained and/or courses passed:……

……..

……..

Trade certificates obtained: ……

In-house training received: ……

Codes of any driver's licenses: ……

4. Employment History:

4.1. Please indicate any previous employment, from your recent to your least recent position.

	Most recent			**Earliest position**
Date Started				
Name of Employer				
Job Title				
Broad description of work done				
Date ceased				
Salary at date of				

leaving				
Details of any commission bonus, overtime etc.				

4.2. When was the last day you were able to fulfill all the normal duties of your job:……

4.3. What alternative occupation(s) do you consider yourself qualified for by education, training and experience?

……

4.4. When do you expect to take up any job in the future:
Please indicate full or part-time, and the nature of the job

……

……

4.5. What is your current employment status?
Please tick relevant box

Employment Status	√
Working Full Time	
Working Part Time	
On Sick Leave	
On Unpaid Leave	
Laid off or Retrenched	
Dismissed	

5. Banking Details:

Bank:……Branch Code:……

Bank Account Number:……Account Type:……

6. Medical Information:

6.1. List of complains ……..

……

……

6.2. State the date and details of your accident/injury/illness:……

……

……

……

6.3. Please describe your symptoms:……

……

……

6.4. Details of any hospitalizations within the past two years:

Name of hospital			
Date of admission			
Date of discharge			

6.5. Details of any surgery performed in the past ten years:……

……

……

6.6. Your hospital numbers pertaining to any hospitals you have attended for treatment:

Name of hospital			
Hospital number			

6.7. Please state all medication you are currently receiving including the dosage:……

7. Details of Medical Practitioners:

Please state the details of the medical practitioners currently attending to you.

7.1. General Practitioner:

Name of practitioner:……

Date First Seen:……Telephone Number:( )……

Fax Number:( )……Postal Address:……

……

7.2. Specialist:

Name of specialist:……

Date First Seen:……Telephone Number:( )……

Fax Number:( )……Postal Address:……

……

7.3. Specialist:

Name of specialist:…….

Date First Seen:……Telephone Number:( )……

Fax Number:( )……Postal Address:……

……

8. Income details

8.1. Income prior to your impairment:

Normal salary or wagers per month	Bonus or overtime (p.m. average last year)	Commission (p.m. average last year)	Other

8.2. Current or expected future income:

Source of income e.g. Employer, self-employment, insurer, UIF			
Amount of income			
How payable (Monthly, lump sum)			
Date of commencement of payment			
Policy number(s) (if applicable)			

DECLARATION

I declare that all the particulars given on this claim form are to the best of my knowledge true and correct, and that no material information has been withheld or omitted.

I hereby authorise any medical practitioner, hospital or any other person who has information about my health to provide such information to SA Quantum or any interested party nominated by SA Quantum who requires this information for the purposes of assessing my claim.

I hereby authorise SA Quantum to furnish any medical information contained in medical reports or otherwise which they have obtained during the course of the assessment of my claim to any medical practitioner or allied medical practitioner who may require such information for the purpose of assisting SA Quantum in the assessment of my claim.

I hereby consent to and authorize SA Quantum to disclose information related to my medical and functional status, to trustees of the fund and persons related to the assessment of my claim, as deemed necessary for the purposes of making a recommendation in respect of my claim for disability benefits.

Claimants Signature:……

Witness:……

Date:……

JOB DESCRIPTION

In respect of a disability claim

This form must be cmpleted in full by the member's supervisor in conjunction with the member. The information given must be complete and accurate.

1. Member Details

Name of applicant: .....

Date of birth: .....

Telephone number:.....

Postal address:.....

Employer:.....

2. Job Tasks

2.1 Job title:.....

Please list the important or regularly performed tasks:.....

.....

.....

.....

.....

.....

3. Work Environment

What percentage of the working day does the member work:

Indoors:……%

Outdoors:……%

At heights:……..%

At depths:……..%

Temperature range in place of work:…… degrees Centigrade

Decibel range in place of work:…… decibels

Is the member exposed to any dust while working?

YES	NO

Please list the type of dust the member is exposed to:……

Is the member exposed to any fumes while working?

YES	NO

Please list all fumes the member is exposed to: ……

4. Physical Demands

Does the member's job involve any of the following?

Lifting weights	**YES**	**NO**	Range of weights lifted:_____ kg
Carrying weights	**YES**	**NO**	Range of weights carried:_____ kg
Pushing weights	**YES**	**NO**	Range of weights pushed:_____ kg
Pulling weights	**YES**	**NO**	Range of weights pulled:_____ kg

Does the member's job involve any climbing?

Type of climbing (e.g. stairs, ladders, scaffolding)

Please indicate how much time is spent on the following activities during each working day. (Tick the relevant column.)

	Never	Sometimes	Often	Always	Hours per day
Sitting					
Kneeling					
Standing					
Walking					
Walking on even terrain					
Walking on uneven terrain					
Use of both hands					
Use of fine coordination					
Engaging in physical labour					
Reaching above shoulder height					
Reaching below shoulder height					
Working in cramped conditions					

Where the member's job involves walking, please indicate:

Average distance walked over even terrain per day:……km

Average distance walked over uneven terrain per day:……...km

Where the member's job involves manual labour, please specify the tasks involved:

……

……

……

Please list all items used during the course of the member's work:

Equipment used:……

Tools used:……

Materials used:……

Machinery used:……

5. Driving

5.1 Only complete this section if driving is a component of the member's job.
License code(s) required:……
Type of vehicle(s) driven:……
Average distance driven:
Per day:……km
Per week:……km
Per month:……km

5.2 Does the member operate earth moving machinery?

If YES, specify the type:……

6. Flying

Only complete this section if flying is a component of the member's job

Average distance flown per week:……

Average number of hours flown per week:……..

7. Cognitive demands

Please indicate how much of the member's job requires the following abilities during each working day. (Tick the relevant column)

	Never	Sometimes	Often	Continuously	Hours per day
Concentration					
Memory					
Planning					
Problem solving					
Decision making					
Administration/ clerical tasks					
Calculations/ figure work					

8. Cognitive Demands

Please indicate how much of the member's job requires the following abilities during each working day. (Tick the relevant column.)

	Never	Sometimes	Often	Continuously	Hours per day
One: one communication					
One: group communication					
Verbal communication					
Written communication					
Communication with colleagues					
Communication with clients					

Is the member responsible for the supervision of any staff?

If YES, number of staff supervised……

9. Safety Hazards

Please give details of any safety hazards in the member's job:

……

……

What other alternative jobs with the company would the member be capable of performing?

……

……

DECLARATION
We the undersigned, hereby declare that the above details are to the best of our knowledge true and correct and that no material information has been withheld or omitted.

Full name of supervisor:……

Supervisor's designation:……

Signature of supervisor:…… Date:……

Signature of member:……Date:……