

MUNICIPAL WORKERS RETIREMENT FUND



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 the 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:.....

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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			

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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)?

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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)			

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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:.....

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JOB DESCRIPTION

In respect of a disability claim

This form must be completed 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:.....
.....
.....
.....
.....
.....

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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

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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					

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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:.....

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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					

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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?

.....

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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:.....