DISABILITY CLAIM FORM - DECLARATION BY EMPLOYER

Real People Assurance Company Limited is a registered Financial Services Provider (FSP 26634)
Reg. No. 2001/028918/06 | Real People Views | 12 Esplanade Road | Quigney | East London | 5201
P.O. Box 19610 | Tecoma | 5214

for REAL PEOPLE®

SUBMISSION OF CREDIT LIFE CLAIMS: FACSIMILE 086 623 4234 | HELPDESK: 086 111 4803 | E-MAIL: rpcreditlife@realpeople.co.za
SUBMISSION OF CLAIMS FOR OTHER POLICIES: HELPDESK 086 111 4803 | FAX TO 086 623 4080 | E-MAIL realinsuranceclaims@realpeople.co.za

To be completed by the employer in full or if self-employed, to be completed by the auditor / bookkeeper or relevant third party

A. TO BE COMPLETED IN FULL

Policy / Loan number

Employee number

Full name of employee

ID number

Initial date of employment D D M M Y Y Y Y

On what date was the employee last able to undertake 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. health retirement / retrenched / boarded etc.) If the reason for termination relates to boarding.

Please attach the relevant document

Until what date was any remuneration paid?

D D M M Y Y Y Y

Was the employee in full time or part-time employment?

Details of remuneration during the past 12 months

What was the employee's designated occupation?

What was the exact nature of the employee's work? (Please give 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", furnish reasons

Has any consideration been given to the availability or any other suitable work?

Yes No

If "no", furnish reasons

If "yes", was such work accepted by the employer from start date?

Please note that in the event of any modification or variation of this standard form Real People Assurance Company will regard this form as being invalid and of no force and effect.

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

If "no", state reason why

B. OTHER INSURANCE

Have you been approached by any other insurance Companies for information relating to the employee's current state of disability? | Yes | No

If "yes", please provide details of the name of the Insurer and the relevant contact numbers if in your possession

Is the employee entitled to any other disability benefits? (e.g. benefits from pension fund, group life etc.) | Yes | No

If "yes", please provide the relevant details

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, detail of their practice must be provided)

Name & Surname	
Position / Relationship	
Company	
Physical Address	
Telephone number	
Facsimile number	
E-mail address	

Signed at (Place) | On (date) D D M M Y Y Y Y

Company Stamp

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