KZN
MUNICIPAL PENSION FUND
Together We Grow Your Wealth

Disability Claim - Employee Declaration

Part 1: Employee to complete this form

The request for completion of this form in no way constitutes an admission of liability by the trustees. This declaration will form the basis on which the claim is assessed. Please ensure that each question is answered and the information given is complete and accurate. Distortion of information could be used as a basis for the claim being declined.

Please attach: A copy of member's ID/Passport :

We will also require the Disability Claim Employer Declaration and Confidential Medical Report - and copies of all relevant medical investigation findings in order to assess this claim.

Completed form to be sent to the relevant Human Resources Department at the Municipality or sent directly to **KZN Municipal Pension Fund, 16 Floor, 22 Dorothy Nyembe Street, The Marine Building, Durban Central, 4001. Contact Number: 031 322 9001**

1. Member details

Title | Initials

First name/s

Surname

Date of Birth D D - M M - Y Y Y Y

RSA ID | Yes | No | ID/Passport No.

Marital status | Married | Single | Divorced | Widowed

Home Language

Tel No. Home | Cell

Tel No. Work | Fax

Email

Residential address

Postal code

Postal Address

Postal code

Income tax number

Do you belong to a medical aid | Yes | | No |

If yes, give details; Name of scheme

Membership no:

2. Details of Occupation

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

Date when you started in your current occupation/ position: D D - M M - Y Y Y Y

Job title: _____

Details of duties. List FIVE main performance areas with a brief description of each:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you been able to perform part of your job, or another job, since your impairment | Yes | | No |

If you have performed another job, or if your job was changed give details of the job that you did, the date that it changed/started, and salary that you were paid.

_____

_____

_____

3. Details of employment history

Apart from your present occupation,please supply a brief employment history, including previous positions held at current and previous Employers

Date started	Date ended	Company	Position held	Type of work	Salary at date of leaving	Reason for leaving

4. Qualifications, training and experience

	Year achieved	Standard/ Qualification
Highest level of schooling:		
Technical qualifications (NTC,diplomas etc):		
Academic qualifications (e.g degrees, etc,):		
Other training (e.g certificates, in-house training, driver's licences & codes		

What alternative occupation/s do you consider yourself qualified for?

5. Details of impairment

Date last able to actively perform your normal occupation: D D - M M - Y Y Y Y

Date last able to perform an alternative occupation: D D - M M - Y Y Y Y

When do you expect to be able to take up any occupation in the future?

On part-time basis? D D - M M - Y Y Y Y

On full-time basis? D D - M M - Y Y Y Y

What is your current employment status? Please tick the appropriate box.

Working full-time	Working part-time	On sick leave	On unpaid leave
Laid off or retrenched	Dismissed	Other	

If other, please specify _____

Please complete if your impairment arose from an accident or other violent means:

Date of accident: D D - M M - Y Y Y Y

What type of accident/incident occurred? _____

Police station where reported: _____

Police case number: _____

List of diagnoses/symptoms/complaints	Date first noticed
	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y
	D D - M M - Y Y Y Y

How does the impairment affect you in doing your normal duties?

_____

_____

Which duties can you no longer do?

_____

_____

Which duties can you still do?

_____

_____

Have you, in the last 5 years, suffered from any serious disease, illness or disablement? Yes ☐ No ☐

If yes, please provide details

Details of any hospitalizations within the last 2 years

Name of hospital	Date of admission	Date of discharge	Reason for admission	Surgery performed

Current treatment. Please list all medication you are on, provide name and dosage

6. Current activity profile

Please indicate your hobbies and interests:

Please indicate how you generally spend your day since you have been suffering from the impairment:

06h00 – 07h00	
07h00 – 08h00	
08h00 – 09h00	
09h00 – 10h00	
11h00 – 12h00	
12h00 -13h00	
13h00 – 14h00	
14h00 – 15h00	
16h00 – 17h00	
17h00 – 18h00	
18h00 – 19h00	
19h00 – 20h00	
20h00 – 21h00	
21h00 – 22h00	

7. Income detail

Income prior to your impairment

Normal salary or wages per month	Bonuses or overtime (monthly average last year)	Commission (monthly average last year)	Other

Current or expected future income

Source of income eg employer, self employment, other insurance, UIF, Workman's compensation etc			
Date of commencement of payment			
Amount of income			
How payable (monthly, lump sum)			
Policy number/s (if applicable)			

8. Declaration & consent to collect and share personal and health information

Declaration

I declare that to the best of my knowledge all the particulars given on this claim are true and correct, and that no material information has been withheld or omitted. I understand that any false and/or misrepresentation of information could be used as basis for the claim being declined.

Consent to collect and share personal information and health information

KZN Municipal Pension Fund will require the collection of personal,medical and health information in order to assess your disability claim.

I hereby confirm that I know and understand this consent I am providing to KZNMPF herein and I am doing so of my own free will.

	D	D	-	M	M	-	Y	Y	Y	Y
Signature of Member	**Date**									