KZN
MUNICIPAL PENSION FUND
Together We Grow Your Wealth

Disability Claim - Employer Declaration

Part 2: Employer 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.

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 No. 0313229001

1. Member details

Title | Initials

First name/s

Surname

Date of Birth

RSA ID Yes | No | ID/Passport No.

Date joined company D D - M M - Y Y Y Y

Date joined scheme D D - M M - Y Y Y Y

Employee No.

2. Employer details

Contact person at work

Designation

Tel No. | Fax

Email

Address

Postal code

3. Reason for notification

Reason for notification (Please tick the appropriate criteria)

Absenteeism

- ☐ Absent from work for 10 consecutive days
- ☐ Absent from work for five days in 30 days period, without medical evidence or notifying the company
- ☐ Consistently absent for one or more days per month
- ☐ Total absence of 20 days or more in any one year

Productivity Loss

- ☐ Marked loss of productivity due to physical and/or psychological conditions

Injury

- ☐ Injury on duty requiring treatment, hospitalization or absence from work
- ☐ Injury off-site requiring treatment, hospitalization or absence from work

Impairment

- ☐ Employee complaint of disability/impairment/difficulty in meeting work requirements
- ☐ Employee declared disabled / unfit for work by treating doctor
- ☐ Employee has medical condition requiring treatment hospitalization or absence from work

4. Details of employment history

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

	Most recent	Previous	Earlier Position
Date started			
Job title			
Broad description of work done			
Date ceased			
Salary at date of cessation			
Reason for cessation			

5. Salary history

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

Date				
Amount of Increase				
New Salary				
Frequently paid (weekly, monthly or annually)				
Reason for change (annual increase, annual bonus, promotion)				
Date ceased				

6. Details of disablement

When did the illness first become evident or injury occur

D	D	-	M	M	-	Y	Y	Y	Y

Last day actively able to perform normal full time duties of own occupation

Last day physical at work?

Was the member in active full-time and permanent employment on the last day of work?

Yes		No	

Details of any attempts and efforts made to adapt the member's work environment to accommodate their Impairment/s

Which aspects of the member's most recent job is he/she unable to do and why?

If the member has been subject to any particular pressures, either at work or outside of work, please comment on these

Can the member be placed in another/alternatives occupation? Yes No

If No, please state why not

If Yes, please give details of possible alternatives

Has the impairment/disability affected the member's salary Yes No

7. Declaration by employer

I hereby declare that all particulars furnished in this form and accompanying documents are true and correct and that no material information has been withheld or omitted.

Name of person completing this form

Designation

Telephone

Email

Signature of Employer

D D - M M - Y Y Y Y

Date