

3.

4.

5.

(c) Have you been able to perform part of your job, or another job, since your impairment?

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

2.3 Apart from your present occupation, please supply a brief job history, including previous positions held.

Dates		Company	Position held	Type of work done
From	To			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Qualifications, training and experience

3.1 Highest level of schooling:

Year	Standard
<input type="text"/>	<input type="text"/>

3.2 Technical qualifications (NTC, diplomas, etc.):

Year	Qualifications
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

3.3 Academic qualifications (e.g. degrees, etc.):

Year	Qualifications
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>



4.7 Date that you first visited your current general practitioner?

4.8 When was your last consultation?

4.9 What alternative occupation(s) do you consider yourself suitable for and what training do you think would be needed for this/these occupations?

5. Personal details:

5.1 Please indicate your hobbies and interests:

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

06h00 - 07h00

07h00 - 08h00

08h00 - 09h00

09h00 - 10h00

10h00 - 11h00

11h00 - 12h00

12h00 - 13h00

13h00 - 14h00

14h00 - 15h00

15h00 - 16h00

16h00 - 17h00

17h00 - 18h00

18h00 - 19h00

19h00 - 20h00

20h00 - 21h00

21h00 - 22h00

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

If "Yes", please give details of the disease, illness or disablement.



5.4 Do you belong to a medical aid? If "Yes", please give details: Yes No

Name of scheme:

Membership number:

When did you join? Give date:

When will your membership stop/when do you expect it to stop?

6. Other compensation

6.1 Please list those other sources of compensation which you may receive as a result of your disability:

	Workman's Compensation	Pension or Provident Fund	Disability policies arranged by employer	Disability policies arranged by yourself
Estimated amount of benefit:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
How is benefit payable, e.g. monthly lump sum?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date benefit is or becomes payable: (dd mm yyyy)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
For how long is the benefit payable?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

6.2 Have you received any income since the date of disability? If yes, please state:

Amount of income and date/s received

Source of income: – e.g. employer, insurance

CONSENT FORM

I, the undersigned,

identity number (hereinafter referred to as the "Member"), hereby

confirm that I have submitted a disability claim against the

(scheme/fund) and hereby authorise any medical practitioner, hospital, my employer or any other person who may have any information whatsoever relating to my illness/injury, to furnish an authorised official of Metropolitan Limited (hereinafter referred to as the "Insurer") with such information.

I hereby also authorise the Insurer to disclose and/or release the aforementioned information to any other party whose opinion is required for the assessment of a disability claim and indemnify the aforementioned party and the Insurer against any loss, damage or injury that I may incur in any manner whatsoever, directly or indirectly, as a result of the furnishing of such information.

Finally, I hereby authorise the disclosure of the aforementioned information to my legal representative should it be required.

Dated at this day of year

Witness

Member of the scheme/fund

