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Noble Private Portfolios
Independent Asset Managers

STANLIB

Disability Claim Form

Classic Range

CLIENT DETAILS

INVESTMENT ACCOUNT NUMBER

NAME/S

SURNAME

IDENTITY/PASSPORT NUMBER

DATE OF BIRTH - - (D D M M Y Y Y Y)

NAME OF MEDICAL SCHEME

INCOME TAX NUMBER

PERSONAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW/ WIDOWER

IF MARRIED, PLEASE STATE OCCUPATION OF SPOUSE

CLIENT'S PHYSICAL ADDRESS

COMPLEX / UNIT / HOUSE NUMBER

COMPLEX NAME / ESTATE

STREET NUMBER

STREET NAME / FARM NAME / AREA NAME*

SUBURB / DISTRICT*

CITY / TOWN*

COUNTRY* CODE*

*Compulsory fields

CLIENT'S POSTAL ADDRESS

☐ SAME AS PHYSICAL ADDRESS

PO BOX NUMBER

POST OFFICE NAME

POSTAL CODE

PRIVATE BAG NUMBER

POST OFFICE NAME

POSTAL CODE

POSTNET SUITE NUMBER

PRIVATE BAG NUMBER

POST OFFICE NAME

POSTAL CODE

CURRENT OCCUPATION (ALSO APPLICABLE IF SELF-EMPLOYED)

EMPLOYER NAME

CONTACT DETAILS

WHAT WAS YOUR JOB TITLE BEFORE YOUR CURRENT DISABILITY IMPAIRMENT BEGAN?

GIVE AN ACCURATE DESCRIPTION OF THE EXACT DUTIES AND THE NATURE OF YOUR FULL-TIME OCCUPATION (JOB DESCRIPTION)

ADMINISTRATIVE % SUPERVISORY % MANUAL % TRAVEL %

THE LAST DATE YOU WERE ABLE TO UNDERTAKE ANY PART OF THE DUTIES OF YOUR OCCUPATION? D D - M M - Y Y Y Y

WHEN DO YOU EXPECT TO RETURN TO WORK? (IF POSSIBLE) D D - M M - Y Y Y Y

HAVE YOU BEEN OFFERED OR DID YOU ENQUIRE ABOUT ANY ALTERNATIVE OCCUPATION FOR REMUNERATION BY YOUR EMPLOYER? YES NO

IF "YES", DESCRIBE DUTIES OF ALTERNATIVE OCCUPATION OFFERED BY YOUR EMPLOYER

HAVE YOU ACCEPTED THE ALTERNATIVE OCCUPATION THAT WAS OFFERED? YES NO

FULL-TIME BASIS D D - M M - Y Y Y Y

PART-TIME BASIS D D - M M - Y Y Y Y

WHAT IS YOUR EXPECTED REMUNERATION? R .

IS THE ABOVE MENTIONED YOUR NOMINATED OCCUPATION YES NO

IF YES, HOW LONG HAVE YOU BEEN IN THIS OCCUPATION? M M - Y Y Y Y

EMPLOYMENT HISTORY

Occupations held in the past 10 years

EMPLOYER	JOB TITLE	FROM DATE	TO DATE	BRIEF DESCRIPTION OF EMPLOYMENT

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			
Increase amount / percentage			
New salary			
Frequency paid (weekly/monthly/annually)			
Reason for change (annual increase, annual bonus, promotion			
Estimated amount of additional earnings through overtime, commissions etc.			

INFORMATION RELATING TO YOUR INCOME

STANLIB reserves the rights to call for proof of income and sight of relevant tax forms

WHAT WAS YOUR TAXABLE INCOME FOR THE PAST 12 MONTHS? R .

COMMISSION EARNED DURING THE PAST 12 MONTHS? R .

DIRECTOR'S CHARGES FOR THE PAST 12 MONTHS? R .

HAVE YOU RECEIVED ANY INCOME SINCE DISABLEMENT? ☐ YES ☐ NO

IF "YES", PLEASE STATE INCOME AMOUNT FOR EVERY MONTH SINCE DISABLEMENT

PLEASE PROVIDE DETAILS OF THE SOURCE OF INCOME

HAVE YOU LODGED OR INTEND LODGING A CLAIM FOR PAYMENT OF DISABILITY BENEFITS WITH ANY OTHER PARTY? ☐ YES ☐ NO

NAME OF OTHER PARTY	POLICY NUMBER	DATE OF INCEPTION	ESTIMATED VALUE

ARE YOU CURRENTLY RECEIVING ANY OTHER BENEFITS? ☐ YES ☐ NO

IF YES, PROVIDE MORE DETAILS

INFORMATION RELATING TO IMPAIRMENT

NATURE OF DISABILITY/IMPAIRMENT(S)

INDICATE IF YOUR IMPAIRMENT(S)/DISABILITY IS DUE TO ☐ ACCIDENT/TRAUMA ☐ DISEASE/ILLNESS

DATE OF IMPAIRMENT D D - M M - Y Y Y Y

IF THE DISABILITY/IMPAIRMENT IS A RESULT OF AN ACCIDENT, WHEN, WHERE AND HOW DID THE ACCIDENT OCCUR?

FULL DETAILS OF INJURIES SUSTAINED

NAME OF POLICE STATION

CASE NUMBER

HAVE YOU INSTITUTED A CLAIM FOR BENEFITS AGAINST THE MULTILATERAL MOTOR VEHICLE FUND? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE A REFERENCE NUMBER UNDER WHICH THE CLAIM WAS LODGED

If the disability/impairment is due to illness/disease, please provide the following details

DATE THE ILLNESS WAS FIRST DIAGNOSED D D - M M - Y Y Y Y

Attending doctor/s including specialist/s

NAME

STREET

SUBURB

CITY/TOWN

COUNTRY POSTAL CODE

TELEPHONE NUMBER - TELEPHONE NUMBER -

NAME

STREET

SUBURB

CITY/TOWN

COUNTRY POSTAL CODE

TELEPHONE NUMBER - TELEPHONE NUMBER -

WHAT PRESCRIBED TREATMENT ARE YOU CURRENTLY TAKING/USING?

General practitioner during the last 5 years

NAME

STREET

SUBURB

CITY/TOWN

COUNTRY POSTAL CODE

TELEPHONE NUMBER - TELEPHONE NUMBER -

HAVE YOU BEEN CONFINED TO A HOUSE BED HOSPITAL

DURATION DAYS MONTHS YEARS

History of all medical consultations/treatments over the last 5 years (treatments for colds and flu may be omitted)

DATE	REASONS	TREATMENT	HOSPITAL/DOCTOR	TELEPHONE

DETAILS OF HOSPITALISATION WITHIN THE LAST 2 YEARS

NAME OF HOSPITAL

DATE OF ADMISSION - - (D D M M Y Y Y Y)

DATE DISCHARGED - - (D D M M Y Y Y Y)

Attending doctor/s including specialist/s

NAME

SURNAME

CONTACT DETAILS

EMAIL/FAX NUMBER

NAME

SURNAME

CONTACT DETAILS

EMAIL/FAX NUMBER

HAVE YOU BEEN CONFINED TO A HOUSE BED HOSPITAL

DURATION - - (D D M M Y Y Y Y)

BANKING DETAILS FOR PAYMENTS

Payments to third party bank accounts are not allowed. Payments can only be paid into an account in the name of the client.

BANK

BRANCH BRANCH CODE

ACCOUNT NUMBER

ACCOUNT TYPE CHEQUE SAVINGS TRANSMISSION

ACCOUNT HOLDER'S ID NUMBER

ACCOUNT HOLDER'S NAME

SUPPORTING DOCUMENTATION

Please attach the following supporting documentation with the completed claim form:

- Declaration by Employer to consider Disability Claim and to verify that the information is correct
- Medical Reports completed by the Medical Doctor who is currently treating the Client;
- Declaration by the Medical Specialists who have been treating the Client stating that the Client is disabled and unable to find Employment due to the disability;
- Detailed report from the Specialist treating the Client;
- Hospital reports
- A copy of the Accident Report if the Disability was caused by an accident.

INVESTOR DECLARATION

1. I/We acknowledge that I/We provide consent to STANLIB to collect, process, store, disclose and share my Personal Information for the purpose of servicing my investment.
2. I/We agree to provide all documentation and information requested in this document and further required by law and consent to STANLIB processing my information for the purposes stipulated within the Terms and Conditions.
3. I/We confirm that all information provided herein is true and correct and that I/We have read and understood the contents of this form.
4. I/We acknowledge and accept that the information contained in this form and information about the Account Holder may be provided to SARS. Further, that SARS may also exchange the information with the tax authorities of another country or countries in which the Account Holder may be tax resident.

If the information you have provided in this form changes in future, please submit a new form within 30 days. If you are not the Account Holder please indicate the capacity in which you are signing the form. If signing under a power of attorney please also attach a certified copy of the power of attorney.

SIGNATURE OF CLIENT / AUTHORISED SIGNATORY *

DATE D D - M M - Y Y Y Y

SIGNED AT

CAPACITY

SIGNATURE OF FINANCIAL ADVISER

DATE D D - M M - Y Y Y Y

SIGNED AT