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E-mail: bargainingcouncil@nmg.co.za

Disability Benefit Claim Member Statement

(To be completed by the member) Section A

Tick ☑ where applicable Please use a black pen and block letters

Please note: If there is not enough space provided on the form, please continue on a separate sheet of paper.

A. Member's personal details

1. Scheme name
2. Employer
3. Member's surname
4. First names
5. ID number
6. Tax number
7. Payroll number
8. Date of death (Y Y Y Y M M D D)
9. Date of birth (Y Y Y Y M M D D)
10. Month for which last contribution was paid
11. Member's monthly contribution prior to death R
12. Member's annual income at date of death R

Details of drivers licence

Residential address

code

Postal address

code

Telephone-work (code+number) Fax-work (code+number)

Telephone-home (code+number) Cellphone number

E-mail address Gender Male ☐ Female ☐

Income tax office Income tax number

B. Occupation details

Inception date of current job (Y Y Y Y M M D D)

Date when you were last actively able to do this job (Y Y Y Y M M D D)

Position held

List of main duties

Please supply a brief employment history, including previous positions held.

Dates from	Dates to	Company	Position held	Type of work done (e.g. welding)

Have you been able to perform any part of your main duties or another job since you first became disabled? Yes ☐ No ☐

B. Occupation details (continued)

If "Yes", please give details, including dates, job description and remuneration.

What was the highest level of schooling that you achieved? Standard/grade Year

Please supply details of formal training and any courses which you have attended

Dates from	Dates to	Name of employer, college or institution	Qualification obtained	Brief description of course content

C. Impairment details

List of complaints?

When were these symptoms first noted?

How has this impairment limited you from performing any particular part of your main duties?

Please print the name, address and telephone number of your family doctor or the doctor who is currently attending to you.

Please supply details of all doctors, specialists and hospitals attended during the last five years
(quote hospital number where applicable)

Dates from	Dates to	Hospital or doctor	Address and telephone number	Patient number

D. Particulars regarding income

If you receive or expect to receive any lump sum or periodic payment or any other benefit as a result of your impairment from any employer, insurance company, pension fund, state fund, compensation for occupational injuries and disease act or any other source, please give details.

Source of benefit (state name of company and your reference number)	Type of benefit (e.g. insurance, lump sum)	Amount

Signature of member

Date Y Y Y Y M M D D

I, _____ (full names of member), hereby declare that I am the person assured under the Fund mentioned below. All the particulars given, whether in my handwriting or not, are to the best of my knowledge, true and complete. I accept full responsibility for any inaccuracies or omissions contained in this member statement and I understand that the Fund may bring criminal or civil charges against me in the event that any such inaccuracies or omissions are discovered by the Fund.
I hereby authorise NMG Consultants and Actuaries Administrators (Pty) Ltd (NMG):

a) to obtain from any person, whom I hereby authorise and request to give any information which NMG deems necessary, and
b) so share with other insurers that information and any information contained in this proposal or in any related policy or other document, either directly or through a data base operated by or for insurers as a group, at any time (even after my death) and in such detailed abbreviated code form as may from time to time be decided by NMG or by the operators of such data base.

Please note: The request for completion of the form in no way constitutes an admission of liability by NMG.