BUSINESS DISABILITY BENEFIT (OSRB; OWN AND SIMILAR OCCUPATION) – MEMBER

CLAIM REQUIREMENTS

Please select the business solution for which you are claiming and provide the policy number:

Solution	**Buy-and-sell cover**	**Contingent Liability Cover**	**Credit Loan Account Cover**	**Key Person Cover**
Policy number				

Claims in respect of the PPS Business Disability benefit should be submitted with the following supporting documents:

- Member claim form.
- Claim form completed by the treating medical doctor.
- Detailed medical report and copies of all investigations performed to confirm the diagnosis.
- The Business Assurance Policyholder claim form.

PPS contact details:

Claim submissions:
E: claims@pps.co.za

Claim-related enquiries:
E: memberservices@pps.co.za
T: 0860 123 777 or +27 (0)10 085 3820
Monday to Friday from 07:00 to 19:00 and Saturday from 08:00 to 13:00

PART A: PARTICULARS OF LIFE-INSURED

Member number: Date of birth: D D M M Y Y Y Y

Surname: Initials:

Medical aid name:

Medical aid number:

E-mail:

Cellular:

PART B: CLAIM DETAILS

1. Please state the medical condition for which you are claiming:

Date of diagnosis: D D M M Y Y Y Y

Date of onset of symptoms: D D M M Y Y Y Y

Date of first consultation: D D M M Y Y Y Y

2. Provide brief details of the chronological history (date of onset and progression up to now) of the condition:

3. Did the sickness/disability originate outside of South Africa? YES ☐ NO ☐

If YES, specify in which country:

4. Are you currently working or have you retired from your occupation? If retired, kindly elaborate.

PART C: EMPLOYMENT QUESTIONS RELATED TO THE WORK PERFORMED DIRECTLY BEFORE THE ONSET OF THE SICKNESS/ DISABILITY AND CURRENTLY

1. Please list all your qualifications:

Qualification	**Year obtained**

1.1 Are you registered with a statutory body? YES ☐ NO ☐

1.2 If YES, please indicate your registration number:

1.3 If not registered, provide date of deregistration:

And reason(s):

2. Please state the following:

	Before the onset of sickness/disability	**Currently**
Profession		
Job title		
Full time, part time or private practice (select one that applies)		
Were/are you working: in own occupation, similar occupation or unrelated occupation (select one that applies)?		
Name of institution/company		
Employment start date		
Employment end date		
Number of hours worked per day		

3. List the **occupational duties/tasks** you were able to perform **before the onset of sickness/disability** as well as any other **duties/tasks** you are **currently performing with the sickness/disability**. Allocate % of time spent and indicate the interdependence of your tasks/duties:

Before the onset of illness/disability			**Currently**		
Duty/Task	%Time spent	Interdependence	Duty/Task	% time spent	Interdependence
e.g., Surgery	60%	Consultation with patients	e.g., Surgery	60%	Consultation with patients
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		
6.			6.		
7.			7.		
8.			8.		

4. Have you been medically boarded? YES ☐ NO ☐

If YES, please state the date you were boarded:

and the name and contact details of the person in charge of the boarding process:

5. Please state whether your surgery/rooms/administrative offices are currently: still open ☐ closed ☐

5.1 Date closed: D D M M Y Y Y Y

5.2 If still open, provide details of who is running your surgery/rooms or administrative offices.

Name:

Contact details:

6. How do you currently occupy your day (without professional activities)?

7. What discomfort/difficulty do you currently experience that prevents you from practising your professional duties in the same capacity as before your sickness/disability?

8.

8.1 List the accommodations or adaptations that have been implemented or explored (since the onset of the sickness/disability) to enable you to carry out all or some of your occupational duties in the same capacity as before your sickness/disability.

Note: Adaptations mean any alterations or adjustments to the work environment (e.g., small adjustment to your working hours and workload or adjustments to your work area), which makes carrying out your occupational duties easier or possible:

8.2 Kindly indicate which of these adaptations have not been feasible and provide a reason why.

8.3 Contact details (name and phone number) of person(s) at work that can be contacted about the accommodations made at work:

Name:

Contact details:

PART D: QUALITY OF LIFE DETAILS

Rate to what extent your sickness/disability has affected the following areas in your life:

Note: Rate the questions on a scale from 1-10 (1) being no changes to (10) being severe. If your rating is 4 or greater, please explain how it has impacted the specific area in the space provided.

1. Your usual daily activities i.e., bathing, dressing. (Scale from 1-10)

2. Were you able to drive a motor vehicle before your sickness/disability? YES ☐ NO ☐

   If YES, to what extent does your sickness/disability impede this function? (Scale from 1-10) ☐☐

3. When do you suffer from pain? (e.g., end of day, night time)

4. Describe your sleeping pattern:

5. Comment on the impact that your sickness/disability has on the following functions:

Function	**Impact due to sickness/disability**
Concentration	
Memory	
Self-confidence/self-esteem	
Ability to socialise	

6. Have there been adaptations/adjustments to your home? YES ☐ NO ☐

6.1 If YES, please give details (e.g., any railing, ramps):

7. Please indicate your level (e.g., seldom, often, frequent) of participation in non-professional activities, such as tennis, golf, gardening.

Detail of activity	**Before sickness/disability (seldom/often/frequent)**	**Currently (seldom/often/frequent)**

8. Do you handle your own personal finances? YES ☐ NO ☐

If NO, why not:

9. What do you consider as your two most disabling symptoms?

10. Have you submitted a claim for disability benefits with another company for this same sickness/disability? YES ☐ NO ☐

If yes, please provide the name of the company:

Contact person name and surname:

Phone number:

PART E: AUTHORISATION TO COMMUNICATE WITH FINANCIAL ADVISER

I specifically authorise PPS Insurance to communicate any requirements to my financial adviser which may entail providing information regarding my current medical condition. YES ☐ NO ☐

Financial adviser's name:

Financial adviser's e-mail :

PART F: DECLARATION

The Professional Provident Society (PPS) Holdings Trust No IT 312/2011 is a Registered South African Trust. The Professional Provident Society Insurance Company Limited Reg. No 2001/017730/06 is a licensed insurer conducting life insurance business, a licensed controlling company and an authorised financial services provider. Any reference to PPS in this form means PPS Insurance.

I _____ (member full name and surname) and ID number: _____

authorise PPS Insurance to:

a) Access any information deemed necessary to assess any insurance risk or to consider a claim. I understand that if I choose not to provide this information, PPS will not be able to assess the claim for insurance.

b) Share with other insurers and their representative body any information in the possession of PPS Insurance, either directly or through a database operated by, or for insurers as a group and authorise PPS to also collect my personal information from other insurers as exchange of information helps to save costs and combat fraud. PPS can further process any such information in accordance or compatible with the purpose for which it was collected.

c) Disclose any information to the PPS Holdings Trust, PPS Insurance's subsidiaries and affiliates or other persons provided that it is necessary to properly underwrite, manage, assess the claim or service the policy, policy assets or myself. PPS Insurance may be required to disclose my information to regulatory or government agencies.

d) Obtain credit information from any person or institution.

AND

I understand that I can request details of the information held by my insurer and request its correction where appropriate.

AND

I authorise a doctor, hospital, medical aid or any other person to provide this information to PPS. PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS will adhere to any laws governing the protection of (and access to) personal information and will not use your information for any purpose not provided for in your Policy Contract and in this Part F.

Signed at _____ on this _____ day of _____ 20 _ _

Signature of life-insured: _____

DISCLAIMER:

By submitting this form electronically, you acknowledge that your electronic signature holds the same legal weight as a handwritten signature. For authorised electronic signature details, contact your PPS-accredited financial adviser or e-mail memberservices@pps.co.za. Using unauthorised electronic signatures is at your own risk and PPS Insurance disclaims liability for any related issues.