Menlyn Corporate Park, Block A, 175 Corobay Avenue
Waterkloof Glen Extension 11, Pretoria, 0081
PO Box 284, Menlyn 0063, South Africa
Tel +27 (10) 590 7700 Fax +27 (86) 471 6539 enquiries@stangen.co.za

Salary protection claim form

Once you've completed the form, please email it to claims@stangenlife.co.za; or fax it to us at 087 942 725 and our claims team will take it from there; or phone us on 010 020 7655.

Section A

Particulars of the insured			
Policy Number			
Surname			
First Names			
Title	☐ Miss ☐ Mrs ☐ Mr ☐ Dr ☐ Prof	Initials	
ID. Number			
Postal Address			
		Postal Code	
Physical Address			
		Postal Code	
Telephone (w)		Fax (w)	
Telephone (h)		Fax (w)	
Cell-phone			
Communication Preference		☐ Post ☐ Fax ☐ Email	
Email Address			
Date of Disability			
Detailed description of cause of disability:			
Describe your symptoms and how they affect your ability to perform your occupational duties:			

Have you previously suffered from the same or similar illness				☐ Yes ☐ No
If yes, from which date				
On what date did the symptoms of the disability, for which you are claiming for start				
From what date have you been totally disabled and unable to follow your normal occupation				
Which duties of your normal occupation are you not able to do				
What is your	Height	m	Weight	kg

Details of your family doctor				
Surname				
Telephone (w)			Initials	
Physical Address				
			Postal Code	
State the names, addresses and date of all doctors, hospitals and clinics consulted in connection with your condition, (please provide hospital or clinic reference numbers)				
A.	Doctor			
	Hospital/clinic			
	Address			
			Postal Code	
	Date attended		Ref. Number	
B.	Doctor			
	Hospital/clinic			
	Address			
			Postal Code	
	Date attended		Ref. Number	
C.	Doctor			
	Hospital/clinic			
	Address			
			Postal Code	
	Date attended		Ref. Number	
Medical Aid Name			Medical Aid Number	

Section B

Accident details			
Where did the accident take place		Date of accident	

Nature of accident:

1. Details of witness			
First Name			
Surname			
Title	☐ Miss ☐ Mrs ☐ Mr ☐ Dr ☐ Prof		
Physical Address			
		Postal Code	

2. Details of witness			
First Name			
Surname			
Title	☐ Miss ☐ Mrs ☐ Mr ☐ Dr ☐ Prof		
Physical Address			
		Postal Code	

Details of police station where accident was reported			
Name of Police Station			
Physical Address			
		Postal Code	
Telephone Number		Case Number	
Full name, rank and police number of investigating officer:			
Details of any legal action taken as a result of the accident:			

Details of police station where accident was reported			
Doctor			
Telephone Number		Initial	
Physical Address			
		Postal Code	

Section C

Employer details					
1.	Name of current Employer				
	Employee/Clock Number		Telephone (w)		
	Employment Address				
			Postal Code		
	Date when you started working for your current employer				
	Date when you were last actively able to do this job				
	Type of Work				
	Position Held				
	Percentage of hours spent on:		Travelling		%
			Administration		%
			Supervision		%
			Manual Labour		%
2.	Name of previous Employer				
	Employee/Clock Number		Telephone (w)		
	Employment Address				
			Postal Code		
	Employment start date		To end date		
	Percentage of hours spent on:		Travelling		%
			Administration		%
			Supervision		%
			Manual Labour		%
3.	Name of previous Employer				
	Employee/Clock Number		Telephone (w)		
	Employment Address				
			Postal Code		
	Employment start date		To end date		
	Percentage of hours spent on:		Travelling		%
			Administration		%
			Supervision		%
			Manual Labour		%

4.	Name of previous Employer				
	Employee/Clock Number		Telephone (w)		
	Employment Address				
			Postal Code		
	Employment start date		To end date		
	Percentage of hours spent on:		Travelling		%
			Administration		%
			Supervision		%
			Manual Labour		%

Section D

Bank details of the insured	
Bank	
Account holder	
Account no.	
Account type	
Branch code	
Branch name	

Signature of Account Holder

Date

Declaration and authorisation by the claimant	
Policy Schedule Number	

Declaration

I/we _____ declare that to the best of my/our knowledge all the information that I/we have given in this claim form is accurate and complete and that I/we have not withheld any information which could influence the decision on this claim. I/we further declare that I/we understand that my/our failure to disclosre relevant information in respect of this claim may invalidate the claim. I/we acknowledge that I/we fully understand the contents of this declaration.

I/we acknowledge that I/we fully understand the contents of this declaration.

Authorisation

I/we hereby authorise Stangen or any of its representatives to obtain any information regarding this policy from any doctor, insurer or elsewhere that may be necessary to investigate this claim. I/we further authorise Stangen or any of its representatives to release any information regarding to this claim to any other interested parties that it deems necessary in respect of this claim.

I/we warrant that I am/we are legally entitled to the proceeds under this policy and that my/our estate(s) are solvent and have not been ceded or sequestrated.

Signed on_____ day of _____20 _____.

_____
Signature

Section F

To be completed by Stangen.

Policy Schedule Number	
Policy commencement date	
Date Claim received by Stangen	
Details of Claims Committee Decision	

_____ _____
Name Position

_____
Signature