APPLICATION FOR PAYMENT OF
SALARY PROTECTION CLAIM

PARTICULARS OF THE INSURED

Policy Schedule Number			
First Names			
Surname		Title	Miss Mrs Mr Dr Prof
Initials	Gender Female Male		Language
ID / Passport / Card Driving Licence Official Number			
Postal Address			
		Postal Code	
Physical Address			
		Postal Code	
Telephone (w)		Fax (w)	
Telephone (h)		Fax (h)	
Cellphone		Communication Preference	Post Fax e-mail
E-mail address			
Date of Disability	Y Y Y Y M M D D		

Detailed description of cause of disability

Describe your symptoms and how they affect your ability to perform your occupational duties:

	Yes	No
Have you previously suffered from the same or similar illness?		

	Y Y Y Y M M D D
If yes, from which date?	
On what date did the symptoms of the disability, for which you are claiming 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	Initials
Physical Address	
	Postal Code
Telephone (w)	

State names, addresses and dates of all doctors, hospitals and clinics consulted in connection with your condition, (please provide hospital or clinic reference numbers)

A. Doctor	Address
	Postal code
Hospital / Clinic	Ref. No.
Tel Number	Date attended Y Y Y Y M M D D

B. Doctor	Address
	Postal code
Hospital / Clinic	Ref. No.
Tel Number	Date attended Y Y Y Y M M D D

C. Doctor	Address
	Postal code
Hospital / Clinic	Ref. No.
Tel Number	Date attended Y Y Y Y M M D D

Medical Aid Name	Medical Aid Number

SECTION B: ACCIDENT DETAILS

Where did the accident take place?

Date of the accident Y Y Y Y M M D D

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

Tel Number | Case Number

Full name, rank and police number of investigation officer:

Details of any legal action taken as a result of the accident:

DETAILS OF THE DOCTOR CONSULTED AS A RESULT OF THE INJURY

Doctor	Initial
Address	
	Postal code
Tel Number	

SECTION C: EMPLOYER DETAILS

Name of Employer	Employee / Clock No
Employment Address	
	Postal Code
Telephone (w)	
Date when you started working for your current employer	Y Y Y Y M M D D
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 ☐☐ %

1. Name of Previous Employer	Employee / Clock No
Employment Address	
	Postal Code
Telephone (w)	

Employed from start date Y Y Y Y M M D D to end date Y Y Y Y M M D D

Type of Work	Position Held

Percentage of hours spent on:

Travelling ☐☐ % Administration ☐☐ % Supervision ☐☐ % Manual Labour ☐☐ %

2. Name of Previous Employer | Employee / Clock No

Employment Address

Postal Code

Telephone (w)

Employed from start date Y Y Y Y M M D D to end date Y Y Y Y M M D D

Type of Work | Position Held

Percentage of hours spent on:

Travelling % Administration % Supervision % Manual Labour %

3. Name of Previous Employer | Employee / Clock No

Employment Address

Postal Code

Telephone (w)

Employed from start date Y Y Y Y M M D D to end date Y Y Y Y M M D D

Type of Work | Position Held

Percentage of hours spent on:

Travelling % Administration % Supervision % Manual Labour %

SECTION D: BANK DETAILS OF THE INSURED

Name of Bank | Branch Name

Account Number | Branch Code

Name of Account Holder | Account Type

Signature of Account Holder | Date Y Y Y Y M M D D

SECTION E: DECLARATION AND AUTHORISATION BY THE CLAIMANT

Policy Schedule Number

Declaration

I declare that to the best of my knowledge all the information that I have given in this claim form is accurate and complete and that I have not withheld any information which could influence the decision on this claim. I further declare that I understand that my failure to disclose relevant information in respect of this claim may invalidate the claim.

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

Authorisation

I hereby authorise Different Life 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 further authorise Different Life or any of its representatives to release my information regarding this claim to any other interested parties that it deems necessary in respect of this claim.

Signed at _____

Signature of Claimant _____

	Y	Y	Y	Y	M	M	D	D
Date								

Signature of Commissioner of Oath / Justice of the Peace _____

	Y	Y	Y	Y	M	M	D	D
Date								

Official Stamp

SECTION F: TO BE COMPLETED BY DIFFERENT LIFE

Policy Number	Commencement date of policy								
		Y	Y	Y	Y	M	M	D	D

Date Claim received by DIFFERENT LIFE								
	Y	Y	Y	Y	M	M	D	D

Details of Claims Committee Decision

Name	Position

Signature _____