



## Employer Declaration

**Please note:**

- Complete all sections of this form, and ensure that it is signed and stamped before submitting it.
- Attach the following to this form:
  - Copy of payslip as at the last day actively at work
  - Copy of the employer-issued job description
  - Any medical certificate/medical information that the claimant may have
  - Sick leave records for the last 2 years preceding their date of disability

The completed form, together with supporting documents, must be faxed, emailed or submitted to a Capitec Bank branch.

### Section 1: Details of employee

First Names	<input type="text"/>									
Surname	<input type="text"/>									
ID /Passport Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of Employer	<input type="text"/>									
Employer's Physical Address	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Postal Code	<input type="text"/>	<input type="text"/>
Name of contact person at the company	<input type="text"/>									
Telephone Number (h)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Email/Fax	<input type="text"/>	<input type="text"/>
Cellphone Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
Designation	<input type="text"/>									
	<input type="text"/>									
Cellphone Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Email/Fax	<input type="text"/>	<input type="text"/>
Date employee joined company	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Did the employee work full time?								Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Date on which the employee returned to work (if they have returned after disability):	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date the employee was last actively at work	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Section 1: Details of employee (continues)**

What is the employees current employment status?

- |                        |                          |  |                          |
|------------------------|--------------------------|--|--------------------------|
| Working full time      | <input type="checkbox"/> | Working part time                      | <input type="checkbox"/> |
| On paid sick leave     | <input type="checkbox"/> | On unpaid leave                        | <input type="checkbox"/> |
| Laid off or retrenched | <input type="checkbox"/> | Under notice of termination of service | <input type="checkbox"/> |

What was the date of termination of service

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

**Section 2: Employee's occupation details (please attach their job description) before stopping work**

Occupation

Summary of main duties, including hours worked before stopping work

To what extent does the employee need to do the following in an average work day?

Strength	How much?	What?
Lift – kilograms		
Carry – kilograms/metres		
Push – kilograms/metres		
Pull – kilograms/metres		
Hold – kilograms/metres		
Endurance	How much?	What or where?
Climb – metres		
Stoop – percentage of day		
Stand – percentage of day		
Sit – percentage of day		
Walk – smooth terrain	Metres p/d	
Walk – uneven terrain	Metres p/d	
Accuracy	How much?	What or where?
Fine, precise movements		
Control of tools		

Describe the minimum mental abilities that a healthy individual requires to do this job

	Very often	Often	Seldom
Literacy			
Numeracy			
Memory			
Problem solving			
Decision making			
Specialised knowledge			
Speaking			
Writing			
Listening			
Reading			
Public Speaking			

**Section 2: Employee's occupation details (continues)**

To what extent does the employee have to cope with the following demands on their body?:

	All the time	Most of the time	Some of the time	Never
Jarring				
Cold				
Heat				
Noise				
Dust				
Fumes				

In which of the following environments does the employee perform their duties?:

	All the time	Most of the time	Some of the time	Never
Outdoors				
Indoors				
Heights				
At Depths				

Working hours (include shift work if applicable) before stopping work

Have any attempts been made to adapt the employee's work environment to accommodate the condition, before stopping work? Yes  No

If Yes, please provide a description

Specify the percentage of time spent on

Task	Percentage
Managerial	
Administration/clerical	
Supervisory	
Light manual	
Heavy manual	
Travel	
Machine operator	

What percentage and hours does your employee work each day?

	Percentage	Hours		Percentage	Hours
Outdoors			At depth		
Indoors			Wet areas		
Heights			Dry areas		

**Section 2: Employee's occupation details (continues)**

How often is the employee exposed to the following conditions?

	<b>Always</b>	<b>Sometimes</b>	<b>Seldom</b>	<b>Never</b>	<b>Hours a day</b>
Dust					
Vibration					
Noise					
Fumes					
Heat					
Cold					

Temperature range in place of work

Type of dust and fumes, if any?

Provide details of any safety hazards in the claimant's job

List all items, equipment, tools, materials and machinery used

How much time is spent on the following activities during the normal working day?

	<b>Always</b>	<b>Sometimes</b>	<b>Seldom</b>	<b>Never</b>	<b>Hours a day</b>
Sitting					
Standing					
Walking on even terrain (specify kilometers a day)					
Walking on uneven terrain (specify kilometers a day)					
Kneeling					
Stooping					
Bending					
Crouching					
Squatting					
Climbing					
Use of both hands					
Use of fine coordination					
Vision					
Hearing					
Physical strength or power					
Reaching above shoulder					
Reaching below shoulder					

Only complete the questions below if flying is a part of your employee's job:

Type of airplane flown

Average distance flown each week

Average number of hours flown each week

**Section 2: Employee's occupation details (continues)**

Indicate which of the following are inherent job requirements

	Always	Sometimes
Verbal communication		
Written communication		
Electronic communication		
Telephonic communication		
Communication with clients		
Communication with colleagues		
Reading		
Listening		
Conflict resolution		

**Section 3: Accommodation in the workplace**

Have any attempts been made at realignment to accommodate the employee?

Yes  No

If Yes, describe in which capacity and for what period

What efforts have been made to retain, skill realign the employee in an alternative position?

**Section 4: Medical condition**

Has the employee been injured on duty or developed an occupational disease?

Yes  No

Does the claim relate to an accident?

Yes  No

Does the claim relate to an illness?

Yes  No

If Yes, supply details of the injury, illness or accident.

**Section 5: Declaration**

I hereby declare that, to the best of my knowledge, the particulars above are true and complete. I hereby authorise that the information can be forwarded to Capitec Bank.

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Official Title \_\_\_\_\_

Date 

D	D	M	M	Y	Y	Y	Y

Company Stamp

**Processing of Personal Information in terms of the Protection of Personal Information Act 4 of 2013**

The privacy of our Insured is of utmost importance to us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner. The Insured's Personal Information will be used to assess this disability claim for the Insured. You hereby agree to give honest, accurate and up-to-date Personal Information of our Insured to assist us in assessing the risk insured against.

You acknowledge that any Personal Information supplied to us in respect of the Insured is provided according to the Applicable Laws. Unless consented to by yourself, we will not sell, exchange, transfer, rent or otherwise make available any Personal Information you have provided in respect of our Insured unless it is a requirement in terms of the Applicable Laws.