TRANSPORT SECTOR RETIREMENT FUND

TRANSPORT Sector Retirement Fund
Moving Towards A Better Future

DISABILITY CLAIM

salt EMPLOYEE BENEFITS

MEMBER STATEMENT
To be completed by the member

A. CURRENT EMPLOYER INFORMATION

Name of Employer			
Employer Address			
Region		Employer's Tel. No	
Contact Person's Name		Contact Person's Tel. No	
Contact Person's Email Address		Contact Person's Fax No	

B. MEMBER DETAILS

Surname of Member							
First Name of Member							
Member's Physical Address		Country		Code			
Member's Postal Address		Country		Code			
Employee No		System No					
Gender (Female/Male)		ID/Passport No					
Date of Birth	D D M M Y Y Y Y	Date Joined Fund		D D M M Y Y Y Y			
Date of Disability	D D M M Y Y Y Y	Annual Income at Date of Disability	R	0 0 0 0 0 0 0 0 0			
Date of Last Contribution	D D M M Y Y Y Y	Amount of Contribution	R	0 0 0 0 0 0 0 0 0			
Driver's Licence Number		Expiry Date		D D M M Y Y Y Y			

C. OCCUPATION DETAILS

Highest level of schooling attained	Standard	Year	
Inception Date of Current Job	D D M M Y Y Y Y	**Date at which you were last able to do this job**	D D M M Y Y Y Y
Position Held			
List of Main Duties			

Please supply a brief employment history, including previous positions held

Date from to Date to	Company	Position Held	Type of work done

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

If Yes, please provide details, including dates, job description and remuneration

Please supply details of formal training and any other courses you attended

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

D. IMPAIRMENT DETAILS

List of Complaints:

Provide details of when these symptoms first became apparent:

Describe how these symptoms and or impairment have limited you from preforming any of your main duties:

Name of family doctor or doctor who is currently attending to you		
Address of family doctor or doctor who is currently attending to you		
Contact number of family doctor or doctor who is currently attending to you	Cell No	
	Landline Tel No	
	Fax No	

Please supply details of all doctors, specialists and hospitals you attended in the last five years

Date from to Date to	Hospital or Doctor	Patient Number	Address and Telephone Number

E. 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 provide details

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

F. MEMBER DECLARATION

I, _____(full name) a member of the Transport Sector Retirement Fund (Fund), hereby confirm the and declare that:

All information provided in this Member Statement is true and correct. This Member Statement was completed by me personally, or with the assistance of someone with my approval. I understand the information provided and confirm that same is true and correct. I have not withheld any information that will have relevance to the acceptance / declining of this claim. Should any information be found to be fraudulent, the Fund and / or the Fund Service Providers reserve the right to proceed with the appropriate action against me as the liability to provide accurate and complete information, rests with me. In the event of any loss suffered as a result of any details provided on this Member Statement being inaccurate, incorrect, incomplete or fraudulent, neither the Fund nor the Fund Service Providers will be liable for such loss. I understand that the disability benefit may be subject to taxing in terms of the applicable tax legislation.

Signature of Member: _____ Date Signed: _____

Notes:

In some instances, further documents and /or information may be required to determine the validity of a claim. All documents required in the claim notification must be submitted and failure to do so timeously, may result in claim payments being delayed and / or Disability risk benefit claims being declined. Disability Claims are assessed on receipt of complete documentation, including the fully completed Member Statement, and failure to do so, will result in the delay of processing the claim.

I. SUBMISSION DETAILS

Claim Type	Electronic	Fax	Telephone Enquiries	Physical address
Disability	members@rflipf-sanlam.co.za	011 544 8302	011 544 8300	SALT Employee Benefits (Pty) Ltd, Central Park Office No 400, 16th Road Randjespark Office Block Q, Midrand

SALT Employee Benefits (Pty) Ltd, an authorised Financial Services Provider in terms of the Financial Advisory and Intermediary Services Act 37, of 2002 ("FAIS Act") with FSP Number 18929 is the appointed administrator to Transport Sector Retirement Fund. SALT Employee Benefits is committed to compliance with the requirements prescribed in the FAIS Act. All disclosures are available on request.