Liberty Corporate – Authorised Financial Service Providers
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LIVING LIFESTYLE BENEFIT – RHEUMATOID ARTHRITIS

(Please answer each question in full – do not use a dash, correcting fluid or leave blank. If not applicable, write N/A)

Member name _____

Member's ID number _____

Scheme name _____

Scheme number _____

Employer name _____

Benefit being applied for (Please tick the appropriate box)

☐ Living plan ☐ Progressive living plan ☐ Progressive living plan plus

SECTION A – TO BE COMPLETED BY THE MEMBER OF THE SCHEME

PERSONAL DETAILS

Member's residential address _____

Member's contact details (H) _____ (Cell) _____

(W) _____ (e-mail) _____

DETAILS RELATING TO THE IMPAIRMENT

A) What is the diagnosis of your condition? _____

B) When did this problem start? _____

C) Have you had a history of similar problems in the past? ☐ Yes ☐ No

If "Yes", please provide details

_____

_____

_____

_____

D) What treatment have you received? _____

_____

_____

E) Please advise details of any doctors, clinics or institutions consulted regarding your current impairment or any other illness or injuries in the five-year period prior to the commencement of your current impairment. (If the space is insufficient, please use a separate sheet.)

Name of doctor or institution	Telephone number	Reason for consultation	Date of consultation

Please note that in the event of any modification or variation of this standard form Liberty Corporate will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

F) Have you had any tests or X-rays? ☐ Yes ☐ No

If "Yes", please provide details

G) Have you been confined to bed, house, hospital or nursing home? ☐ Yes ☐ No

If "Yes", state which and provide dates

H) Has there been any improvement in your condition? ☐ Yes ☐ No

If "Yes", please describe:

I) Are you insured for Living Lifestyle benefits with any other insurer, or have you received any benefits regarding this or any other condition from this scheme/Liberty Life or from any other insurer? ☐ Yes ☐ No

If "Yes", please provide details

Name of insurance company	Policy / reference number	Amount of benefit

J) Is there a concurrent disability claim pending with Liberty Life or any other insurer? ☐ Yes ☐ No

If so, please provide details:

DECLARATION

I, the undersigned, _____ (please print your full name) hereby notify Liberty Corporate, that I make claim for payment of benefits under the above scheme. Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks, and the consideration of any claim for benefits, under a policy related to this or any other proposal for insurance made by me, or in respect of me as life assured, I irrevocably authorise Liberty Corporate

(a) to obtain from any person or institution, whom I hereby so authorise and request to give, any information which Liberty Corporate deems necessary, and
(b) to share with other insurers that information and any other information contained in this proposal or in any related policy or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Liberty Corporate or by the operators of such database.

I hereby declare and warrant that I am an active member of the abovementioned scheme, that the impairment was not due in any way to self-inflicted injury, and that the answers given in this claim form are in every respect true and correct and that no material information has been withheld nor details of any relevant circumstances omitted. I am not insolvent.

Signed at _____ Date _____

Witness _____ Member's signature _____

NOTE Subject to the admission of this claim, the benefit payments may be made directly to your bank account. Please provide banking details below and attach an original cancelled cheque or account statement for verification purposes.

Bank _____

Branch _____

Branch code _____

Type of account _____

Account number _____

SECTION B – TO BE COMPLETED BY AN AUTHORISED SIGNATORY OR TRUSTEE OF THE SCHEME

EMPLOYMENT DETAILS

A) Date of commencement of the member's service with the employer _____

B) Date on which the member first became eligible for membership of the scheme _____

C) Was the member employed by you in a full-time capacity? ☐ Yes ☐ No

If "No", please provide details

_____

_____

D) What was the member's main occupation?

_____

_____

E) Is the member presently working? ☐ Yes ☐ No

- If yes, in what capacity, part-time or full time? _____
- If part-time, state the percentage of normal working hours the member is working _____
- If part-time, what occupation is the member now performing?

_____

_____

F) If the member is presently employed but has been unable to work due to a functional impairment, give details of the period he was not at work

From _____ To _____

G) If not at work, on what date was the member last at work? _____

I, the undersigned, in my capacity as the authorised signatory or trustee of the scheme, hereby notify Liberty Corporate that this statement is in support of the member's claim for payment of benefits under the above scheme. I hereby declare and warrant that the above answers are true and correct, that no material information has been withheld or omitted and that the member described above was eligible for membership of the scheme at the date on which the impairment commenced.

_____ _____

Authorised signatory/Trustee's name Signature

_____

Date

Official company stamp

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SECTION C – TO BE COMPLETED BY THE MEMBER'S TREATING SPECIALIST

Chronic inflammatory disease in which there is musculoskeletal and systemic involvement. Diagnosis confirmed by a rheumatologist

MEDICAL HISTORY

A) Are you treating the patient for the impairment that gave rise to this claim? ☐ Yes ☐ No

B) Date of first consultation _____

C) Dates of consultations for the past six months

Dates of consultations	Reason for consultation	Diagnosis	Treatment prescribed

D) When did symptoms first appear? _____

E) Date the diagnosis was confirmed _____

F) Confirmation of the exact diagnosis _____

G) Has the patient ever been treated for a similar condition, any other medical condition that may have contributed to this impairment? ☐ Yes ☐ No

If "Yes" please provide details and dates

_____

_____

_____

_____

_____

H) Do you have results of any special investigations e.g. X-rays, blood test results, etc.? ☐ Yes ☐ No

If "Yes" (Kindly submit copies of these as well as copies of any other reports on file relating to this impairment)

I) Has the patient ever been referred to any other medical practitioner or are you aware of any other medical practitioner, specialist, etc. who has been consulted by the patient for this or any other conditions? ☐ Yes ☐ No

If "Yes" please provide names and dates

_____

_____

_____

_____

_____

J) Has the patient suffered from any complications? ☐ Yes ☐ No

Please supply all details

_____

_____

K) Are you aware of any family history, which may have predisposed the patient to this condition? ☐ Yes ☐ No

Please supply all details

_____

_____

PRESENT CONDITION

	Category	ADL	Major	Moderate
1	Posture and Motion	Walking Standing Stooping Squatting Kneeling Climbing stairs	Unable to perform all of these functions	Requires mechanical aid (walking frame, crutches, wheelchair) to perform all of these functions
2	Movement and self care	Grasping Pincer grip Fine motor Gross motor Holding strength Grip strength	Unable to perform all of these actions bilaterally	Moderately impaired ability to perform all of these functions bilaterally

A) What are the current signs and symptoms?

B) Please confirm to what degree will his/her activities of daily living (ADL) improve with further treatment in relation to the above table (1. Posture and Motion, 2. Movement and self care)

C) Please confirm if all activities under 1. Posture and Motion are mildly or moderately affected?

D) Will these activities be affected on a permanent basis? Please comment on each ADL including: walking, standing, stooping, kneeling and climbing stairs.

E) Please confirm if all activities under 2. Movement and Self Care are moderately or majorly affected?

F) Will these activities be affected on a permanent basis? Please comment on each ADL including; Grasping, Fine Motor, Gross Motor, Holding Strength and Grip Strength.

G) We need to know if he/she is unable to perform all of these actions bilaterally or unilaterally?

H) Please stipulate if there are any deformities noted? ☐ Yes ☐ No
If 'Yes' please indicate the joints/ area affected.

I) Range of movement and muscle strength of the affected joints/area?

J) Patient's height (cm) _____ Patient's weight (kg) _____

K) What assistive devices are necessary to assist him/her with Posture or Motion, Movement and Self Care?
Examples: difficulty standing – device: raised toilet seat or chair leg extenders
Weak grip – device; eating utensils, shoe horns and other tools with large built up handles

L) List all treatment the patient is currently receiving or has previously received for this condition, compliance to the treatment and what the response to this treatment has been.

DECLARATION

I certify that I have personally attended to the patient and that, to the best of my knowledge, the above statements are correct and complete.

Signed at _____ Date _____

Name (please print) _____

Qualifications _____

Address _____

Telephone no _____ Fax no _____

Signature _____

SAMDC number _____ Practice number _____

NOTES

a) The member is responsible for settling medical expenses incurred in initially substantiating any claim.
b) In terms of the Promotion of Access to Information Act, by completing and returning this report to us, you confirm that you are aware of and that you consent to the information being released to the client / patient in the event of the appropriate request in terms of any law, including the Promotion of Access to Information Act No.2 of 2000.