MOTOR INDUSTRY FUND ADMINISTRATORS

APPLICATION FOR PERMANENT DISABILITY

☐ **AUTOWORKERS PROVIDENT FUND** ☐ **MOTOR INDUSTRY PROVIDENT FUND**

NOTE: Payments will **ONLY** be effected **ELECTRONICALLY** into the **MEMBER'S OWN BANKING ACCOUNT.**

Banking details MUST BE SUPPLIED - See Page 2.

FOR OFFICE USE ONLY

REGION	FUND	COUNCIL NUMBER

Contributions received to last day of employment YES ☐ NO ☐

ADDITIONAL INFORMATION:

MEMBER INFORMATION - to be completed by the member

Surname

Full Names

ID number **Certified copy of Identity Book MUST BE attached**

Reason for leaving

Leaving date D D M M Y Y Y Y

Home address Code

Post address Code

Home Tel. No. Cell no.

Email address

Income tax ref number Office

EMPLOYMENT HISTORY

From D D M M Y Y Y Y To D D M M Y Y Y Y

Company

From D D M M Y Y Y Y To D D M M Y Y Y Y

Company

Are you currently employed? YES ☐ NO ☐ If YES, state the name of the Company

BANKING DETAILS

Banking details MUST BE SUPPLIED on a printed bank form.

Member's Council Number

Account Holder Name

Name of Bank

Branch Code

Account Number

Type of Account ☐ Savings ☐ Cheque ☐ Transmission

☐ Other

Account Holder Signature

Full Names and Surname of Bank Official

Bank Official Signature

BANK STAMP

MEMBER DECLARATION AND SIGNATURE

I, the undersigned, hereby certify that the given information is correct in all aspects. I hereby authorize the Fund to deduct from any benefits due to me, an amount which equates to the prescribed Moto Health care contributions in respect of the period during which I received benefits from motto Health care, subsequent to the termination of my employment in the motor industry, and the consequential termination of the membership of Moto health Care.

Member's Signature

D D M M Y Y Y Y

****PLEASE NOTE THE FOLLOWING DOCUMENTATION MUST BE SUBMITTED WITH THIS APPLICATION**

	A certified copy of the member's Identity book
	Medical Booklet
	Copies of Relevant Medical Reports
	Form D completed by the Employer for Retirement claims only
	Completed Certificate of service - by the EMPLOYER (See Page 3)

COMPLETED APPLICATION WITH ALL SUPPORTING DOCUMENTATION MUST BE SENT TO YOUR LOCAL MIBCO OFFICE

REGION	CONTACT NUMBER
MIBCO Eastern Cape PO BOX 7270 PORT ELIZABETH - 6055	(041) 364-0250
MIBCO Natal PO BOX 17263 CONGELLA - 4013	(031) 205-5465
MIBCO Free State OFS PO BOX 910 BLOEMFONTEIN - 9300	(051) 409-4000

REGION	CONTACT NUMBER
MIBCO - HIGHVELD P O BOX 2578 RANDBURG - 2125	(011) 369-7500
MIBCO NORTHERN REGION P O BOX 2578 RANDBURG - 2125	(011) 369-7500
MIBCO WESTERN CAPE P O BOX 17 BELLVILLE - 7535	(021) 948-6400/05

CERTIFICATE OF SERVICE - to be completed by the EMPLOYER

COMPANY NAME ______________________________

This is to certify that the particulars mentioned hereunder are true records of the employment by the company of

Employee Council number

Employee Surname

Employee Full names

Identity Number

Period employed From D D M M Y Y Y Y To D D M M Y Y Y Y

Employee's termination Weekly / Monthly / Annual earnings were R ______________________

Reason for termination of employment - **mark with an X**

- [ ] Retirement - 55 years and older
- [ ] Resignation / Dismissal
- [ ] Retrenchment
- [ ] Disability
- [ ] Death
- [ ] Other - please state: ______________________________

Termination date to be reflected on the Monthly Returns to Mibco D D M M Y Y Y Y

It is hereby acknowledge that the Employer will be held liable for any loss by the Fund in the consequence of a false declaration of retrenchment/ Redundancy.

SIGNED FOR AND ON BEHALF OF THE EMPLOYER

DATE

INITIALS AND SURNAME

DESIGNATION

COMPANY STAMP

Contact number

FORM D

PENSION AND PROVIDENT FUNDS

Member's Council number: ☐☐☐☐☐☐☐☐☐☐

To be completed by the member's employer in all cases where a Form A is applicable, and submitted by the Trustee / Administrator / Insurer of the Fund in conjunction with a Form A to SARS.

Name of Employer ______________________________

Employer's Address ______________________________

____

______________________________ Code __________

1 Employee's Surname ______________________________

Employee's First name ______________________________

2 Highest average salary actually earned by the taxpayer during any five consecutive years in the service of the employer during his membership to the fund.

YEAR	SALARY
	R
	R
	R
	R
	R
	R
	R
TOTAL	R

Average for 5 years or lesser period if employee was employed for a lesser period R

3 To be completed on the death of an employee - twice the salary during 12 months immediately preceding death R

Note: For the purpose of question 2 and 3, 'Salary' includes any amount received or receivable annually under a contract of service as also cost of living allowances, commission, share of profits, etc, but not occasional bonuses or fees which were dependant on the whim of the Directors or employer.

DECLARATION

Certified correct to the best of my knowledge and belief.

____

MANAGER / SECRETARY

D D M M Y Y Y Y

MOTOR INDUSTRY FUND ADMINISTRATORS (PTY) LTD

APPLICATION FOR A DISABILITY BENEFIT

INSTRUCTIONS

PART A	To be completed by member
PART B,C,D	To be completed by employer
	* Note that Part D is to be completed by member's immediate supervisor in conjunction with him / her
PART E	For completion by member's attending doctor / specialist **once Part A to D is completed**

PART A

MOTOR INDUSTRY FUND ADMINISTRATORS (PTY) LTD

APPLICATION FOR A DISABILITY BENEFIT

TO BE COMPLETED BY EMPLOYEE / MEMBER (Please print in black ink)

PENSION FUND NO / FUND NAME ____

FULL NAMES____

IDENTITY NUMBER______________________AGE NOW__________YEARS____________MONTHS

POSTAL ADDRESS____

____CODE____________

TELEPHONE NUMBER HOME _________________________WORK _________________________

CELL NUMBER _________________________ E-MAIL______________________________________

UNION NUMBER______________________________

NATURE OF DISABILITY

____

____

____

____

____

I hereby irrevocably authorise and direct any doctor, or other person/s, who may possess now, or at any time during my life, any information concerning, either directly or indirectly, my health and physical condition (whether such information relates to the past or future) to disclose full details thereof to the Motor Industry Fund Administrators (Pty) Ltd or its nominees

Signed at _______________________this _________day of____________________20__________

WITNESS____________________________________ _________________________

SIGNATURE OF MEMBER

PART B

TO BE COMPLETED BY EMPLOYER

FULL NAME OF EMPLOYER OF COMPANY____

POSTAL ADDRESS____

____CODE____________

NAME AND DESIGNATION OF CLAIMANT'S IMMEDIATE SUPERVISOR______________________

____

CONTACT TELEPHONE NUMBER AREA CODE (__________)________________________

LAST DAY OF ACTIVE EMPLOYMENT______________________________________

NATURE OF ILLNESS / INJURY____

WHEN DID IT START?____

PENSIONABLE SALARY AT DATE OF DISABLEMENT R________________ PER WEEK / MONTH

RECORD OF SICK LEAVE OVER THE LAST YEAR (state specific medical reasons/provide doctor's notes)

COMPLETE **PART C**

TOTAL DAYS OFF DUE TO ILLNESS OVER THE LAST YEAR_________________

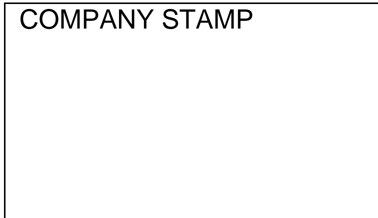
MEMBER'S NORMAL JOB____

EMPLOYER'S RECOMMENDATIONS WITH REGARD TO THIS APPLICATION

____

____

____



FULL NAMES____

DESIGNATION____

SIGNATURE____

TELEPHONE NUMBER (__________) ____________________

FAX NUMBER____

E-MAIL____

PART C

SICK LEAVE RECORD

NAME____

DATES	NO OF DAYS	REASON

PART D

JOB QUESTIONNAIRE (to be completed by employer)

Claimant's Name: ________________________Company Name: __________________

THIS JOB QUESTIONNAIRE IS TO BE COMPLETED AS FOLLOWS:

A. By the claimant's supervisor in conjunction with the claimant.
B. In full, thus reflecting an ACCURATE and TOTAL picture of the Claimant's Occupation prior to the disablement date.

1.1 What was the claimant's job title immediately prior to disablement?__________________

1.2 Give a summary of this job, describing the main responsibilities: ____________________

____

____

2.1 Indicate the percentage of time in this job, spent engaging in:

a. Manual duties ________% b. Supervisory duties ___________%

c. Administration duties _________% d. Driving a vehicle _____________%

This percentage must total 100% and reflect the tasks performed on an <u>average working day</u>

2.2 Give a complete and accurate description of the job components as specified in in point 2.1 above.

a.i) Manual duties ____

____

____

____

____

a.ii) Include details of equipment, tools and materials used _____________________________

____

____

b. Supervisory duties ____

____

____

c. Administration duties ____

____

____

d. Driving a vehicle, eg heavy duty truck, forklift, light delivery vehicle, etc

- State type of vehicle and licensing qualification ___________________________________

____

PART D (cont)

- Please indicate whether the vehicle is a manual gearshift or automatic _______________
- Indicate type of terrain covered ____
- Provide an estimation of distance covered in kilometers over a specified period, eg per day/per week/per month ____
- Any other relevant comments ____

3. Indicate the posture in which the above tasks are performed on an average day, (in a percentage form totaling 100%)

   Sitting ________% Standing ______% Walking ______%

   Climbing ______% Kneeling ______% Crouching ____%

   Cramped/Confined ____% Pushing ______% Pulling _______%

   Carrying/Lifting light weight(<5kg)______% Carrying/Lifting light/medium weight (5-10kg)_ _______%

Carrying/Lifting medium weight (10-25kg) ____________% Carrying/Lifting heavy weight (>30kg) _______%

   Any other posture achieved during performance of a work task

   _____________ ______% _____________ ______%

   _____________ ______% _____________ ______%

   Should the job involve assuming more than one of these postures at one time, eg walking and carrying, please specify and explain below.

   ____

   ____

4.1 Does the job require that the claimant work in any special conditions such as dust, fumes, noise, etc ? Please specify.

   ____

   ____

   Does the job require any specialized skills, trade or vocational training? Please supply details of type and duration.

5. Have any attempts been made to modify the employee's normal duties, or redeployment into an alternate position, in order to accommodate the employee's limitations, as per the requirements of schedule 8 of the Labour Relations Act?

   If yes, please supply the time-span, nature and outcome of such action/s. If no, please Provide substantive details.

____

____

____

6. Please state any other occupations, if any, in which the claimant was involved at the time of disablement.

   ____

   ____

   ____

PART D (cont)

7. Please include any other pertinent information or documents which may assist the Board in formulating an accurate understanding of the claimant's occupation prior to the disablement date.

____

____

____

I hereby declare that the above statements are to the best of my knowledge true and complete.

Signed at __________________ this _________day of _____________________20__________

______________________________	______________________________
Name of claimant	Name of employer
______________________________	______________________________
Signature of claimant	Signature of employer

PART E

TO BE COMPLETED BY THE MEMBER'S DOCTOR / ATTENDING SPECIALIST

PLEASE PRINT IN BLACK INK

1. NAME OF PATIENT______________________________

2. PATIENT'S OCCUPATION______________________________

3. PATIENT NO (if applicable)______________________________

4. HOW LONG HAVE YOU KNOWN AND TREATED ______________________________

5. NAME OF PREVIOUS ATTENDING DOCTOR / SPECIALIST______________________________

6. DATE ON WHICH PATIENT FIRST CONSULTED REGARDING THIS CONDITION___________

7. DATE OF LAST CONSULTATION______________________________

8. PATIENT'S CONDITION______________________________

[a] Diagnosis in detail:______________________________

____

____

[b] Detailed clinical findings:______________________________

____

____

____

____

PLEASE ATTACH COPIES OF ALL RELEVANT SPECIALIST MEDICAL REPORTS AND INVESTIGATIVE TEST RESULTS, IE X-RAYS, SCANS, PATHOLOGY REPORTS, PULMONARY FUNCTION TEST, ETC

9. WHAT IS THE IMPACT OF THE PATIENT'S SYMPTOMATOLOGY UPON FUNCTINOAL ABILITY?

____

____

10. HOW LONG HAS PATIENT HAD THIS CONDITION?______________________________

11[a]. CURRENT TREATMENT AND / OR MEDICATION______________________________

____

[b] YOUR VIEWS ON PATIENT'S COMPLIANCE WITH TREATMENT______________________________

____

PART E (cont)

12. DETAILS OF SURGERY PERFORMED / INDICATED [Include dates and reports]

____

____

13. HAS THE PATIENT BEEN REFERRED TO ANY OTHER DOCTOR OR BEEN TREATED IN HOSPITAL?

YES	NO

IF YES, PLEASE STATE DETAILS AND DATES [INCLUDE COPIES OF REPORTS]

____

____

____

14. IS THIS PATIENT TOTALLY / CONTINUOUSLY DISABLED FOR HIS / HER NORMAL EMPLOYMENT?

YES	NO

PLEASE MOTIVATE

____

____

____

15. PROGNOSIS OF THE CONDITION / ANTICIPATED LEVEL OF RECOVERY

____

____

16. EXPECTED RECOVER / RECUPERATION PERIOD: ______________________________

I certify that I personally examined the patient and that all the foregoing statements are correct to the best of my knowledge

NAME:____PRACTICE NO:____________________

MEDICAL DISCIPLINE: ____

POSTAL ADDRESS: ____

____CODE:______________

TELEPHONE NO __________________FAX NO___________________E-MAIL_____________

SIGNATURE___________________________________ DATE_____________________

THE COST OF THIS MEDICAL EXAMINATION IS TO BE PAID FOR BY THE CLAIMANT