NOTES ON COMPLETION OF THE ILL HEALTH BENEFITS FORM

COMPLETED APPLICATION FORMS WITH ALL SUPPORTING DOCUMENTATION MUST BE SUBMITTED VIA YOUR LOCAL MIBCO OFFICE.

REGION	CONTACT NUMBER
EASTERN CAPE, PO BOX 7270, PORT ELIZABETH - 6055	(041) 364-0250
NATAL, PO BOX 17263, CONGELLA - 4013	(031) 205-5465
FREE STATE, PO BOX 910, BLOEMFONTEIN - 9300	(051) 409-4000
HIGHVELD/NORTHERN REGION, PO BOX 2578, RANDBURG - 2125	(011) 369-7500
WESTERN CAPE, PO BOX 17 BELLVILLE, 7535	(021) 948-6400/05

REASONS FOR WITHDRAWAL: mark with an ✔	✔	**SECTIONS TO BE COMPLETED:** in black ink
Ill Health		A,B,C,E and D(1) & D(2) (if applicable)

Please note: This application cannot be processed unless all information required is provided.
You will note that an identity number is required on each page.

The following documentation is required for ALL above claims

	A certified copy of the member's Identity book
	A cancelled cheque, a bank statement or a bank enquiry printout with the bank account details, stamped by the bank
	A certified copy of the Divorce order (if applicable)
	A certified copy of the retrenchment letter - on a Company letterhead (if applicable)

The following supporting documentation is also required for ILL HEALTH WITHDRAWAL benefit claims

	Supporting medical and doctors' reports

Application for Ill Health Benefits ☐

SECTION A

☐ AUTO WORKERS PROVIDENT FUND ☐ MOTOR INDUSTRY PROVIDENT FUND

Contributions received to last day of employment YES ☐ NO ☐

MEMBER INFORMATION - to be completed by the member

Surname

Full Names

ID number Certified copy of Identity Book MUST BE attached

Council number

Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

RESIDENTIAL ADDRESS

Unit nr:

Complex name:

Street nr:

Street name/Name of farm:

Suburb/District:

City/Town:

Postal code:

POSTAL ADDRESS

Contact No. Cell no.

Email address

Income tax ref number

MEMBER BANKING DETAILS

Bank statement or Bank enquiry printout stamped by the bank MUST BE SUPPLIED

Identity Number

Account Holder Name

Name of Bank

Branch Code

Account Number

Type of Account ☐ Savings ☐ Cheque ☐ Transmission

Other ______________________

If the bank account holder is not the member, then the following must be completed by the member and the account holder.

I: ______________________ of identity nr: ______________________ hereby instruct the Motor Industry Fund Administrators to pay the provident fund benefit due to me into the above given account.

SIGNED BY MEMBER ______________________ | D | D | M | M | Y | Y | Y | Y |

I: ______________________ of identity nr: ______________________ (Copy of my Identity Book) state that I have no objection to the Motor Industry Fund Administrators paying the provident fund benefit due to the above mentioned member into my banking account as per details provided above.

SIGNED BY THE ACCOUNT HOLDER ______________________ | D | D | M | M | Y | Y | Y | Y |

MEMBER'S SIGNATURE & DISCHARGE
I hereby confirm that:
Payment of my benefit as specified herein represents the full and final discharge of the Fund's liability to me as set out in the rules of the Fund; the details provided herein, in particular my banking details, are true and correct in every way.
I understand the options available to me with regard to the payment of my benefits, including the inherent tax implications and that I am making an informed choice;
In the event of any loss suffered as a result of any details provided herein being incorrect, neither the Fund nor the administrator can be held liable for such losses.
I understand the rules of the fund and I confirm that I am fully aware of the implications of the options elected above. I agree that the payment in accordance with the payment instructions as provided will represent full and final discharge of the Fund's liability to me.
I am not aware of any current or pending divorce order or other claim against my retirement fund benefit.

MEMBER SIGNATURE ______________________ | D | D | M | M | Y | Y | Y | Y |

SECTION B

CERTIFICATE OF SERVICE - to be completed by the EMPLOYER

This is to certify that the particulars mentioned hereunder are true records of the employment of the employee.

Employee Council number

Employee Surname

Employee Full names

Identity Number

Company name ______

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

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

Reason for termination of employment ______

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

PREVIOUS EMPLOYER

Company name ______

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

SIGNED FOR AND ON BEHALF OF THE EMPLOYER

INITIALS AND SURNAME
DESIGNATION

Contact number

DATE D D M M Y Y Y Y

COMPANY STAMP

______

EMPLOYER SIGNATURE

SECTION C
SARS 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
   Identity number

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.

NAME

DESIGNATION

SIGNATURE ______________________ D D M M Y Y Y Y

SECTION D

RECOGNITION OF TRANSFER BETWEEN APPROVED FUNDS

GENERAL

In terms of the Income Tax Act (Ac58 of 1962) lump sum at withdrawal / resignation / liquidation are exempt from lump sum tax-:

- if they arise from an approved pension fund and are transferred to another approved pension fund / retirement annuity fund, or
- if they arise from an approved provident fund and are transferred to another approved pension fund / provident fund/ retirement annuity fund.

1. PARTICULARS OF MEMBER Member's Council number

Title ☐ Mr. ☐ Mrs. ☐ Ms.

Surname

Full Names

Income tax ref number Office

I hereby request that a direct transfer of my provident fund benefit be made to:

Name of receiving fund

D D M M Y Y Y Y

MEMBER'S SIGNATURE

2. RECOGNITION OF TRANSFER Policy Number

That

(Name of the Receiving fund) **on receipt of the transfer from the Motor Industry Fund Administrators**, agrees to **apply** this transfer **towards** pension / provident / single premium annuity for the above member.

Fund approval number PAYE number

D D M M Y Y Y Y

SIGNATURE

COMPANY STAMP

3. STATEMENT OF BEHALF OF TRANSFERRING FUND

I, the undersigned, declare on behalf of the

Fund approval number PAYE number

1. that the transferring fund is an approved pension / provident fund (delete which is not applicable), and
2. that the member enjoyed membership until

D D M M Y Y Y Y

COMPANY STAMP

Signed at on this day of 20

SIGNATURE

4. STATEMENT OF BEHALF OF RECEIVING FUND

I, the undersigned, declare on behalf of the

Fund approval number PAYE number

1. that the RECEIVING fund is an approved pension / provident fund (delete which is not applicable), and
2. that R________________has been received for application under the receiving fund on behalf of the member, and
3. that the transfer was in accordance with the stipulation of the Act as defined in paragraph 1 above.

Signed at on this day of 20

SIGNATURE

COMPANY STAMP

PLEASE NOTE: PLEASE COMPLETE SECTION D(2)

SECTION D(2)

DETAILED TRANSFER INFORMATION

(please tick the appropriate option below for the transfer)

1) The total Provident Fund benefit to be transferred to another fund. ☐

OR

2) Portion R__________ paid directly to member and the balace to be transferred to another fund. ☐

OR

3) Special instructions with regards to a transfer to another fund. ☐

____

____

____

____

____

Please note that this option will be considered as final after 7 days following the date of your application.

____________________ ____________________

SIGNATURE OF MEMBER DATE

SECTION E
MEDICAL QUESTIONNAIRE
PART A

☐ AUTO WORKERS PROVIDENT FUND

☐ MOTOR INDUSTRY PROVIDENT FUND

Member's Council number ______________

APPLICATION FOR AN ILL HEALTH BENEFIT
TO BE COMPLETED BY EMPLOYEE/MEMBER (Please print in black ink)

FULL NAMES ______________

IDENTITY NUMBER ______________ AGE NOW YEARS ____ MONTHS ____

RESIDENTIAL ADDRESS

Unit nr: ______________

Complex name: ______________

Street nr: ______________

Street name/Name of farm: ______________

Suburb/District: ______________

City/Town: ______________

Postal code: ______________

POSTAL ADDRESS ______________

CODE ______________

TELEPHONE NUMBER HOME ______________

CELL NUMBER ______________ E-MAIL ______________

NATURE OF PERMANENT ILL HEALTH

Please describe in full how this disability impacts on your ability to perform the requirements of your occupation

____

____

I hereby irrevocably authorize and direct any doctor, or other person/s, who may possess now, or at anytime 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______

____
SIGNATURE OF MEMBER

____
SIGNATURE OF WITNESS

____
INITIALS AND SURNAME OF WITNESS

In order for the benefit to be considered you need to comply with the definition of Ill Health as contained in the Rules of the Fund.

"If a member, in the opinion of the Board, through accidental or ill health has become continuously and permanently unable to perform his usual work in the Motor Industry."

Contact Details of Witness

____

____

SECTION E (cont)
MEDICAL QUESTIONNAIRE
PART B

Member's Council number ____________

TO BE COMPLETED BY EMPLOYER

REGISTERED NAME OF COMPANY ____________

POSTAL ADDRESS ____________

CODE ____________

FULL NAME OF EMPLOYEE ____________

NAME AND DESIGNATION OF CLAIMANT'S IMMEDIATE SUPERVISOR ____________

CONTACT TELEPHONE NUMBER ____________

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 RECOMMENDATION WITH REGARD TO THIS APPLICATION ____________

____

____

COMPANY STAMP

Signed at ____________ this ____________ day of ____________ 20____

SIGNATURE ____________ TELEPHONE NR ____________

FULL NAMES ____________ FAX NR ____________

DESIGNATION ____________ E-MAIL ____________

SECTION E (cont)

MEDICAL QUESTIONNAIRE

PART C

SICK LEAVE RECORD FOR THE LAST 12 MONTHS OF EMPLOYMENT

NAME ______________________________

DATES	NO OF DAYS	REASON

COPIES OF ALL DOCTORS' CERTIFICATES MUST BE ATTACHED

SECTION E (cont)
MEDICAL QUESTIONNAIRE
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 ill-health date.

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

1.2 Give a summary of his 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 average working day

2.2 Give a complete and accurate description of the job components as specified 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, ect

State type of vehicle and licensing qualification ______________________

____

____

SECTION E (cont)

MEDICAL QUESTIONNAIRE

PART D (cont)

e. Please indicate whether the vehicle is a manual gearshift or automatic ______________________

f. Indicate type of terrain covered ______________________

g. Provide an estimation of distance covered in kilometers over a specified period,eg ______________________

per day/per week/per month ______________________

2.3. Any other relevant comments ______________________

3. Indicate the posture in which the above tasks are performed on an average day,

(in percentage from 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. Does the job require that the claimant work in any special conditions such as dust, fumes, notice, ect? Please specify.

____

____

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

____

____

6. 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.

____

____

____

SECTION E (cont)

MEDICAL QUESTIONNAIRE

PART D (cont)

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

8. 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 true and complete to the best of my knowledge.

Signed at __________ this __________ day of __________ 20

NAME OF CLAIMANT

NAME OF EMPLOYER

SIGNATURE OF CLAIMANT

SIGNATURE OF EMPLOYER

SECTION E (cont)
MEDICAL QUESTIONNAIRE
PART E

TO BE COMPLETED BY THE ATTENDING DOCTOR

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 the patient?
5. Name of previous attending doctor / specialist
6. Date on which the patient first consulted you regarding this condition
7. Date of last consultation
8. Patient's condition

[a] Diagnosis in detail:

[b] Detailed clinical findings:

If applicable, CD4 count: Viral load:

(with the patient's consent)

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

9. How does the patient's symptomology impact on his / her functional ability?
10. Date of onset of this condition

11.[a] Current treatment and / or medication

[b] Your views on patient's compliance with treatment

[c] In your opinion, is the patient currently optimally treated?

Please motivate

SECTION E (cont)

MEDICAL QUESTIONNAIRE

PART E (cont)

12. Details of surgery performed / indicated [include dates an 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 the patient totally / continuously disabled for his / her normal employment? ______

    Please motivate

15. Prognosis and anticipated level of recovery

16. Expected recovery / 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 ______

D D M M Y Y Y Y

SIGNATURE

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