PROVIDENT FUND FOR THE FURNITURE MANUFACTURING INDUSTRY OF THE WESTERN CAPE

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APPLICATION FOR A FULL BENEFIT
INCAPACITY IN TERMS OF CLAUSE 10 (C) OF THE PROVIDENT FUND AGREEMENT.

TAX NUMBER:

I. R. P. 5 NUMBER:

COMPANY'S P.A.Y.E. NUMBER:

SURNAME:……...……...

FIRST NAMES:……..……..……...

ADDRESS : ……...……

……..…… **TEL. NO.** ……..……...

ID NUMBER : ……...……... **INDEX NO.:** …….

NAME OF LAST EMPLOYER:……**WAGE PER WEEK**……..
(Last Factory worked at in the Furniture Industry)

DATE OF LEAVING FURNITURE INDUSTRY……

NAME OF PANEL OR HOUSE DOCTOR……

PERIOD OF ENROLMENT IN THE FURNITURE ……..…
(Documentary proof of service to be attached)

BANKING DETAILS - I hereby request and authorise the Provident Fund to deposit my benefit into my bank account.

Name of Bank……..……. Branch Code:……...……..

Account Number:…….. Branch:…….……..

Name of Account Holder ……..…… Type of Account:……..……

I certify that the above particulars are true and correct.

SIGNED ……. **DATE** ……..

FOR OFFICE USE ONLY

LUMPSUM: ……...…… **PART PAYMENT:** ……...……

TAX: ……...…… **CHEQUE NUMBER:** ……...……..

HOUSING LOAN: ……...…… **DATE:** ……...……..

TOTAL: ……...……

ILL HEALTH CLAIM QUESTIONNAIRE
MEMBER'S QUESTIONNAIRE

(Due to permanent incapacity in terms of Clause 10 (C) of the Provident Fund Agreement)

Each question on this form must be answered correctly and in detail.

Please return the application form fully completed and signed without delay.

1) Full name of member : ……..……..

ID. Number: …… Marital Status: …….

Residential Address: ……..

……

Occupation prior to disablement (if more than one, state all)

……...

2) (a) What is the nature of your disablement ?

…….……...

……...

(b) What caused the disablement – injury or illness ?

……...

……...

(c) Give details of injury or illness – when and how caused, etc. ?

…….

……...

……...

3) (a) Are you now, as a result to this disablement, completely or partially unable to carry out your normal working duties, or only part thereof ? Give details.

……..

(b) Could you now engage in any other occupation or work? (If so give details)

……...

4) Are you now in any other occupation or work for remuneration or profit ?
(If so - give details and of duties involved)

…….……...

5) When did your actual disablement commence ?

……...

……...

6) (a) Have you ever before suffered from the cause/s now responsible for you disablement ?
(If so give details)

……...

……...

……...

(b) Please give full name/s and address/es of Medical Attendant/s who treated you, and also the name of the hospital/s or institution/s where you were a patient.

……...

……...

……...

7) Please give full name/s and address/es of Medical Attendant/s who attended and treated you for this disablement.

……...

……...

……...

8) Please give name of any other Medical Attendant, if any, other than at No.7 above.

……...

……...

9) Give full details of Medical treatment undergone by you since your injury or commencement of illness from which your disablement is alleged to have arisen.

……...

……...

10) Are you still receiving treatment for your disablement and, if so, give details.

……...

……...

I, the undersigned, hereby solemnly declare and confirm that the answers and information given in the above questionnaire are true and complete to the best of my knowledge and belief.

By virtue of the information contained herein, I apply to the Provident Fund of the Furniture Industry of the Western Cape to receive a full benefit in terms of the Provident Fund Agreement.

I hereby, irrevocably authorize 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 related to the past or future) to disclose full details thereof to the Provident Fund of the Furniture Industry of the Western Cape.

Signed at …….this……..day of……20…….

_____
SIGNATURE OF CLAIMANT

_____
WITNESS

CONFIDENTIAL DISABILITY REPORT
DOCTORS QUESTIONARE
The cost of this Medical Report will be paid by the Fund

N.B. : This form must be duly completed as soon as possible. Please make your reply sufficiently explanatory to enable the Fund's Medical Officer to assess the nature of the disablement

PRELIMINARY CERTIFICATE OF MEDICAL ATTENDANT

1) Full name of claimant …… Date of Birth…..……..……

Address ……..……

….…….

Occupation/s immediately before his/her current disablement :

…….

2) Are you the claimant's usual medical attendant YES ☐ NO ☐

3) (a) When did the disablement commence ? ……..……..

(b) When did you last attend to the claimant? …….

(c) Are you still attending? If so when last seen? ……..…….

4) (a) Describe fully the nature and extend of claimant's disablement.

……..…

……..…

……

……...

……..…

(b) Describe fully the nature and extend of claimant's disablement.

……..…

……..…

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……...

……..…

4) (c) Describe fully the claimant's present condition :

……

……

…..……

(d) Is the claimant confined to: A) A BED ……..…….

B) THE HOUSE ……..

If neither please give details of his/her activities:

……

……

5) Was the claimant to any other medical practitioner ?
If "YES'', PLEASE STATE

Name ……..…….Date…….

Address …..……

……

6) Was the claimant hospitalized YES☐ NO☐
If "YES'', PLEASE STATE

Name of Hospital ……

Date …….

7) Clinical findings

……

……

……..……...

8) Prognosis

……..…

……..…

……

……..……...

9) Do you think the claimant will in the future be able to engage in any occupation for which he/she could reasonably be considered qualified for?

……..……..……..

……..……...

10) Are you aware of anything in the previous history of the claimant likely to be connected with his/her present illness ?

……..……..

……..……..

……..……..

11) Is there any further information which will assist the patient's claim for disability benefits, and any other remarks pertinent to the patient and his/her ability to follow any occupation in future ?

……..……..

……..……..

……..……..

12) Have any of the following in any way contributed to the claimant's disability?

(a) Self inflicted injuries at any time YES☐ NO☐

(b) Alcoholism or the use of any narcotic drug or such like substance YES☐ NO☐

IF ANY QUESTIONS IN (12) WERE ANSWERED "YES" PLEASE COMMENT FULLY

……..……..

……..……..

……..……..

13) We would be obliged if you could in your medical opinion advise us of the following:

(a) Is the claimant totally and permanently disabled ? YES☐ NO☐

(b) Is there any chance of recovery the future? YES☐ NO☐

(c) Would an operation or therapy accelerate or improve chances of recovery ? If YES, is such an operation or therapy contemplated. If NO, is there any reason why not

……..……..

……..……..

……..……..

……..……..

7…

14) General remarks:

……..……

……..……..

……..……..

……..……..

I CERTIFY THAT I HAVE PERSONALY ATTENTED TO THE PATIENT AND THAT ALL THE FOREGOING STATEMENTS ARE TO THE BEST OF KNOWLEDGE CORRECT.

Signed at ……..……this ……..…….day of ……..……20……

_____
Signature of Doctor

_____
Qualifications

Full postal address ……..…….

……..…….

……..…….

<u>NOTE:</u> THE INFORMATION GIVEN IN THE ABOVE WILL BE TREATED IN STRICT CONFIDENCE BY THE PROVIDENT FUND OF THE FURNITURE INDUSTRY OF THE WESTERN CAPE.