



APPLICATION FOR PERMANENT DISABILITY

(This application form should be completed with the application form for a retirement benefit).
If the benefit is approved you have to retire from the fund.

Please read this section and the Fund's brochure on disability benefits before completing your application form.

1. Please complete all applicable information.
2. The specialists, medical practitioner and occupational health medical practitioner (mine doctor) must read the guidelines.
3. Your employer must complete the declaration and the leave record.
4. Your medical practitioner must complete the attached medical declaration.
5. Regarding your application for disability benefits you should take note of the following legislation, which could have an impact on your situation.
 - 5.1 The Labour Relations Act (1995) gives guidelines for fair labour practices towards ill and disabled employees in the workplace.
 - 5.2 The Employment Equity Act (1998) addresses past discrimination against people with impairments and disabilities and the Code of Good Practice : Key Aspects on the Employment of People with Disabilities (2002) serves as a guide to employers and employees on key aspects of promoting equal opportunities and fair treatment of people with disabilities as required by the Employment Equity Act.
 - 5.3 The Promotion of Equality and Prevention of Unfair Discrimination Bill prevents unfair discrimination and provides for related matters.

Your union or human resources department should be able to assist you with the contents of these Acts and the implication thereof with regard to your disability.
6. Attached to the application form is a guideline for the specialist/physician to use when the assessment team requests more reports.

The following documentation **MUST** accompany your application (Please tick each item indicating if it is included)

- | | |
|---|--------------------------|
| 1. A completed retirement benefit application form. | <input type="checkbox"/> |
| 2. A declaration by your employer (included in the application form). | <input type="checkbox"/> |
| 3. A detailed job description of your last occupation. | <input type="checkbox"/> |
| 4. A declaration by the Medical Officer at the employer (included in the application form). | <input type="checkbox"/> |
| 5. A medical certificate completed by a medical doctor who is currently treating or who has treated you (included in the application form). | <input type="checkbox"/> |
| 6. Any medical reports in your possession relevant to the claim. PLEASE NOTE that additional reports applicable to your disability WILL be requested from you after your application has been screened by the Assessment Team. | <input type="checkbox"/> |
| 7. A copy of your updated record of service. | <input type="checkbox"/> |
| 8. All relevant RMA and/or Medical Bureau documents. | <input type="checkbox"/> |
| 9. A copy of your most recent certificate of fitness. | <input type="checkbox"/> |



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

A. PERSONAL DETAILS

Industry Number				Reference Number			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Title		Initials		Surname			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Identity Number				Passport Number			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Country Where Passport Was Issued				Gender (Please tick block)		Date Of Birth (YYYYMMDD)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Male <input type="checkbox"/>	Female <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
To Which Pension Fund Do You Belong?		Sentinel Mining Industry Retirement Fund		Mine Employees Pension Fund			

ADDRESS DETAILS

POSTAL ADDRESS

P O Box Number	Suburb, City or Town	Postal Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

RESIDENTIAL ADDRESS

Street Number	Street Name	
<input type="text"/>	<input type="text"/>	
Suburb, City or Town		Postal Code
<input type="text"/>		<input type="text"/>

CONTACT DETAILS

Home Tel No.	Code	Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Work Tel No.	Code	Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Fax No.	Code	Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Cell No.		Number
<input type="text"/>		<input type="text"/>
E-Mail.	<input type="text"/>	

FRIEND / RELATIVE DETAILS

Title	Initials	Surname
<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone No	Code	Number
<input type="text"/>	<input type="text"/>	<input type="text"/>



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

B. DETAILS OF MEDICAL CONDITIONS

DETAILS OF YOUR GENERAL PRACTITIONER

Initials and Surname	<input type="text"/>	Telephone Number	<input type="text"/>
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DETAILS OF YOUR SPECIALIST/PHYSICIAN

Initials and Surname	<input type="text"/>	Telephone Number	<input type="text"/>
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Please state the nature of injuries, illness or any other causes of your disability:	<input type="text"/>
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Please describe the symptoms you experience and how they affect your ability to perform your occupational duties:

On what date did the symptoms of the disability start?	<input type="text"/>
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From what date have you been totally disabled and unable to perform your normal occupational duties?	<input type="text"/>
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Which of your normal duties are you able to perform?	<input type="text"/>
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Which not?	<input type="text"/>
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Are you able to manage your daily activities or to care for your personal needs? (Please tick block)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If no, what can you not do?	<input type="text"/>
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APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

C. EMPLOYMENT DETAILS

Date of entry into the mining industry (YYYYMMDD)

Current/Previous Employer

Current/Previous Occupation

Department/Division

If you are a deferred member of the Fund please state your occupation at the time you became a deferred member:

Occupation/job for which you are applying to be found permanently disabled:

Are you still employed? (Please tick block) Yes No If no, date of discharge

Reasons for discharge

Has your employer prior to discharge offered you alternative employment? (Please tick block) Yes No

If yes, what was offered?

If not, reason why alternative employment was not offered?

Have you been transferred/placed on light duties due to your illness/medical condition? (Please tick appropriate block)

Never Temporary Permanent

Date of transfer/placed on light duty Occupation after transfer/light duty

Have you applied for any other work? (Please tick appropriate block) Yes No

Future occupation, should you be found permanently disabled?

D. JOB REQUIREMENTS

Describe your main functions or duties:

WORK ENVIRONMENT:

Environment (Please tick block)	Hours Per Day	Environment (Please tick block)	Hours Per Day	Environment (Please tick block)	Hours Per Day
Office	<input type="checkbox"/> <input type="checkbox"/>	Plant	<input type="checkbox"/> <input type="checkbox"/>	Underground (Developing)	<input type="checkbox"/> <input type="checkbox"/>
Laboratory	<input type="checkbox"/> <input type="checkbox"/>	Workshop	<input type="checkbox"/> <input type="checkbox"/>	Underground (Stopes)	<input type="checkbox"/> <input type="checkbox"/>
Other	<input type="checkbox"/> <input type="checkbox"/>	Production	<input type="checkbox"/> <input type="checkbox"/>	Underground (Shaft)	<input type="checkbox"/> <input type="checkbox"/>



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

D. JOB REQUIREMENTS (CONTINUED)

Specify other:

Specify the physical demands of your job: (Please tick appropriate block)

Physical Demands	Hours Per Day		Physical Demands	Hours Per Day		Physical Demands	Hours Per Day	
Standing	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	Climbing inclines	<input type="checkbox"/>	<input type="checkbox"/>
Walking over even surfaces	<input type="checkbox"/>	<input type="checkbox"/>	Squatting	<input type="checkbox"/>	<input type="checkbox"/>	Crawling	<input type="checkbox"/>	<input type="checkbox"/>
Walking over uneven surfaces	<input type="checkbox"/>	<input type="checkbox"/>	Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	Lifting of heavy objects	<input type="checkbox"/>	<input type="checkbox"/>

If you are lifting heavy objects specify weight and type:

Specify any other requirements that can be attributed to your job (e.g. endurance, supervisory tasks, decision-making etc.)

Specify functions or duties of your work, which you cannot do:

Describe the environmental factors which may have a negative impact on your ability to perform your regular duties (i.e noise, pressure differences, high or low temperatures, dust):

Reasonable accommodations (changes/adjustments) your employer implemented to modify your work (i.e work schedules) and/or work environment.

Did your employer make any reasonable changes to modify your working environment or job functions to enable you to perform your job? (Please tick block)

Yes No

Describe:



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

E. INFORMATION REGARDING THE MEDICAL BUREAU FOR OCCUPATIONAL DISEASES (CONTINUED) (Only applicable if your claim is related to a compensatable lung disease)

Have you been certified to be suffering from a compensatable disease? (Please tick appropriate block) Yes No

If YES, to what degree? 1st 2nd

Do you suffer from any other lung disease? Yes No

Please Specify:

VERY IMPORTANT
 • If you suffer from a compensatable disease, a letter from the Medical Bureau confirming this must be provided.
THE CLAIMS COMMITTEE CANNOT CONSIDER YOUR APPLICATION WITHOUT THIS INFORMATION

F. MINE ACCIDENT

INFORMATION REGARDING RAND MUTUAL ASSURANCE (Only applicable if you ever had an injury on duty. It must be relevant to the condition that caused your disablement which prevented you from performing your own and similar occupations. Please complete from your own records.)

Date of accident(s) Place of accident(s) Mine

Date of accident(s) Place of accident(s) Mine

Date of accident(s) Place of accident(s) Mine

Type of accident: (Please tick appropriate block)

Noise induced hearing loss	<input type="checkbox"/>
Dermatitis	<input type="checkbox"/>
Other	<input type="checkbox"/>

Description of accident(s) (what happened?)

Nature of injuries (broken bone, etc.)



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

F. MINE ACCIDENT (CONTINUED)

Was the accident reported to your employer? (Please tick block) Yes No

If not, why?

Has Rand Mutual Assurance accepted liability? Yes No

Has Rand Mutual Assurance finalised the claim? Yes No

If not, when will the claim be finalised?

Claim Number The percentage permanent disablement awarded? %

Date when this was awarded: (YYYYMMDD) Date when award was paid to you: (YYYYMMDD)

***VERY IMPORTANT**
A copy of a letter from Rand Mutual Assurance confirming this information must be provided as well as a specialist report.
THE CLAIMS COMMITTEE CANNOT CONSIDER YOUR APPLICATION WITHOUT THIS INFORMATION

G. INFORMATION REGARDING THE COMPENSATION COMMISSIONER

Only applicable if you ever had an injury on duty at an employer who does not belong to Rand Mutual Assurance.

Date of accident Place of accident

Description of accident

Has the Compensation Commissioner accepted liability? Yes No

Has the claim been finalised? Yes No

If not, when will the claim be finalised?

Claim Number The percentage permanent disablement awarded? %

Date when this was awarded: (YYYYMMDD) Date when award was paid to you: (YYYYMMDD)

***VERY IMPORTANT**
A copy of a letter from the Compensation Commissioner confirming this information must be provided.
THE CLAIMS COMMITTEE CANNOT CONSIDER YOUR APPLICATION WITHOUT THIS INFORMATION



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

H. IN YOUR OWN WORDS, PLEASE MOTIVATE YOUR APPLICATION FOR TOTAL AND PERMANENT DISABILITY FOR YOUR OWN AND ALL OTHER SIMILAR OCCUPATIONS IN A SPECIFIC ENVIRONMENT.

Multiple empty rectangular boxes for providing a detailed response to section H.

Consent

I, _____ (Please print initials and Surname) the undersigned, hereby give my unconditional consent that the Mine Employees Pension Fund/Sentinel Mining Industry Retirement Fund or any person delegated by it to do so, may contact Rand Mutual Assurance Company, the Medical Bureau for Occupational Diseases, my employer, fellow employees, family members, union/association, medical officer or any other person or institution for information deemed necessary to consider my application for disability benefits. The information obtained will be treated as strictly confidential.

I understand that failure to provide such consent or supplying the relevant information on this form may prejudice my application to be found permanently disabled by the Mines Employees Pension Fund/Sentinel Mining Industry Retirement Fund.

Signed on this Day of 2 0 at

Signature

Large empty rectangular box for the applicant's signature.



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

I. DECLARATION BY EMPLOYER (To be completed by HR Department)

This declaration is in support of a claim for disability being submitted by an employee. It provides vital information to the Disability Assessment Team of MEPF and Sentinel and warrants careful consideration.

In terms of the Labour Relations Act, Basic Conditions of Employment Act and the Employment Equity Act, employers are required to provide reasonable accommodation to a disabled employee and may not discriminate against any disabled person on any grounds.

Employee's Industry Number:	Employee's last permanent position:
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input style="width: 100%;" type="text"/>

Department:	<input style="width: 85%;" type="text"/>
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Section/environment where the employee performed his duties:	<input style="width: 55%;" type="text"/>
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State previous positions held by employee at your company:	<input style="width: 55%;" type="text"/>
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<input style="width: 100%;" type="text"/>

Has the employee been accommodated in another position due to his medical condition? (Please tick block)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If yes, state position:	<input style="width: 85%;" type="text"/>
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Were any reasonable accommodations (changes/modification to work) offered to the employee?	<input style="width: 35%;" type="text"/>
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<input style="width: 100%;" type="text"/>

<input style="width: 100%;" type="text"/>

Reason, if any, why the work place accommodations were not offered or were not successful:	<input style="width: 35%;" type="text"/>
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<input style="width: 100%;" type="text"/>

<input style="width: 100%;" type="text"/>

State the main job functions of the employee's last permanent occupation:	<input style="width: 55%;" type="text"/>
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<input style="width: 100%;" type="text"/>

<input style="width: 100%;" type="text"/>

List the functions the employee is unable to perform:	<input style="width: 65%;" type="text"/>
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<input style="width: 100%;" type="text"/>

<input style="width: 100%;" type="text"/>

What environmental factors with regard to the employee's job functions prohibit him to perform his duties?	<input style="width: 30%;" type="text"/>
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<input style="width: 100%;" type="text"/>

<input style="width: 100%;" type="text"/>

<input style="width: 100%;" type="text"/>

Describe the exact nature of the employee's profession/occupation for the last 24 months before he/she became unable to work.

<input style="width: 100%;" type="text"/>

<input style="width: 100%;" type="text"/>

<input style="width: 100%;" type="text"/>

<input style="width: 100%;" type="text"/>



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

I. DECLARATION BY EMPLOYER (To be completed by HR Department) (Continued)

IDENTIFY THE PHYSICAL ACTIVITIES THE EMPLOYEE PERFORMED DURING A TYPICAL WORK DAY (Please tick block)

0 = No exposure	1 = Low exposure	2 = Medium exposure	3 = High exposure		
Walking	<input type="checkbox"/>	Squatting	<input type="checkbox"/>	Use of left hand	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	Use of right hand	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	Lifting	<input type="checkbox"/>	Use of both hands	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	Pulling	<input type="checkbox"/>	Feeling	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	Pushing	<input type="checkbox"/>	Handling	<input type="checkbox"/>
Standing	<input type="checkbox"/>	Carrying	<input type="checkbox"/>	Physical endurance	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	Holding	<input type="checkbox"/>	Psychological endurance	<input type="checkbox"/>

DETAILS OF DISABILITY

On what date did the employee become disabled? (YYYYMMDD)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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What was/is the cause?

<input type="text"/>

Is the employee in your opinion totally and permanently disabled and unable to follow his/her normal duties?

Yes

No

If yes, please give full details:

<input type="text"/>

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Is/was this attributable to an accident in the course of his/her duties? (Please tick appropriate block)

Yes

No

If yes, please give full details:

<input type="text"/>

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Was the accident reported? (Please tick appropriate block)

Yes

No

If yes, please supply claim number:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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If no, please specify details why not:

<input type="text"/>

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

J. DECLARATION BY OCCUPATIONAL HEALTH MEDICAL PRACTITIONER:

(The medical officer at the medical station of the employer MUST complete this section. A copy of your most recent certificate of fitness MUST be attached.)

Bureau Number:	<input type="text"/>	Date of last examination:	<input type="text"/>	Expiry date:	<input type="text"/>
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Restrictions, if any:	<input type="text"/>
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<input type="text"/>

<input type="text"/>

What, in your opinion has been the underlying cause of this condition?	<input type="text"/>
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<input type="text"/>

<input type="text"/>

In your opinion, is there functional impairment due to the disease/illness or medical condition? (Please tick block)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If yes, please give full details:	<input type="text"/>
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<input type="text"/>

<input type="text"/>

<input type="text"/>

DETAILS OF OCCUPATIONAL HEALTH MEDICAL PRACTITIONER:

Title	Initials	Surname
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<input type="text"/>	<input type="text"/>	<input type="text"/>
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Qualifications:	<input type="text"/>
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Tel No. (Work)	Code	<input type="text"/>	Number	<input type="text"/>
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Fax No.	Code	<input type="text"/>	Number	<input type="text"/>
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Cell No.	<input type="text"/>	Number	<input type="text"/>
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E-Mail	<input type="text"/>
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I declare that to the best of my knowledge, the information in this report is accurate and complete and that I have not withheld any information which could influence a decision on this claim.

Signed on this	<input type="text"/>	Day of	<input type="text"/>	2	0	at	<input type="text"/>
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Signature

<input type="text"/>



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

K. MEDICAL CERTIFICATE FOR A DISABILITY CLAIM

The specialist, physician or general practitioner (not the mine medical officer) treating the medical condition MUST complete this form in full. The patient must pay any costs incurred.

DETAILS OF PATIENT

Title	Initials	Surname
<input type="text"/>	<input type="text"/>	<input type="text"/>
Identity Number		Passport Number
<input type="text"/>		<input type="text"/>

DETAILS OF MEDICAL CONDITION

How long have you known the patient professionally?

When were you first consulted about the patient's present medical condition?

In your opinion, what has been the underlying cause of this condition?

Please give a full description of the patient's present physical/mental state:

What treatment/surgery is the patient receiving at present and to what degree will further treatment relieve the symptoms?

Has the maximum medical improvement been reached? (Please tick appropriate block) Yes No

If no, please give details:

What is the long term prognosis?



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

K. MEDICAL CERTIFICATE FOR A DISABILITY CLAIM (CONTINUED)

DETAILS OF MEDICAL CONDITION (CONTINUED)

What special investigations were done and what were the results?

Are you considering any further treatment or operations?

What were the results of your clinical evaluation to determine the functional status of the patient (reflexes, muscle strength, range of movement, lung functions, etc.)?

Have you treated the patient for any other physical or mental condition?

Yes No

If yes, please give details:

DETAILS OF PATIENT'S DISABILITY

In your opinion, is there functional impairment due to the medical condition?

Yes No

If yes, please give details:

How does this affect the patient's activities of daily living?



APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

DECLARATION BY DOCTOR:

Title	Initials	Surname
<input type="text"/>	<input type="text"/>	<input type="text"/>

Qualifications:

Tel No.	Code	<input type="text"/>	Number	<input type="text"/>
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Fax No.	Code	<input type="text"/>	Number	<input type="text"/>
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Cell No.	<input type="text"/>	Number	<input type="text"/>
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E-Mail

Signed on this Day of 2 0 at

I declare that to the best of my knowledge, the information in this report is accurate and complete and that I have not withheld any information which could influence a decision on this claim.

Signature



GUIDELINE FOR MEDICAL SPECIALIST/PHYSICIAN

These guidelines should be made available to the Specialist/Physician when the assessment team requests more reports.

1. THE RULES OF THE FUND

The Rules make provision for the payment of a disability benefit provided that the member can satisfy the Claims Committee that he/she is totally and permanently disabled for his/her own and any other similar occupations in a specific environment.

Total and permanent disability can be defined as the continuous permanent inability of a member, due to an accident, injury, disease or illness to engage in his/her own and any other similar occupations in a specific environment.

2. THE FOLLOWING CRITERIA SHOULD BE APPLIED IN ASSESSING PERMANENT DISABILITY

- a) The disability must be total and permanent.
- b) The applicant must be permanently disabled for his/her own and any other similar occupations in a specific environment. (Specific environment = Mining Industry)

3. OCCUPATION CATEGORIES

Even though the Rules of the Fund specifically indicate that a member has to prove permanent disability for his/her own occupation, occupations as such can be divided into five categories irrespective of underground or surface work. This can be useful as the medical officer, in many instances, refers to these occupation categories when making a recommendation regarding permanent disability.

3.1 Non-physical/sedentary work

Exerting up to 4.5kg of force occasionally (activity or condition exists up to a third of the working day) and/or a negligible amount of force frequently (activity or condition exists up to two thirds of the working day) to lift, carry, push, pull or move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

3.2 Light physical work

Exerting up to 9kg of force occasionally; and/or up to 4.5kg of force frequently; and/or negligible amount of force constantly (activity or condition exists two thirds or more of the working day) to move objects. Physical demand requirements are in excess of those for sedentary work. Even though the weight lifted might only be a negligible amount, a job should be rated light work when:

- 3.2.1 It requires walking or standing to a significant degree, or
- 3.2.2 It requires sitting most of the time, but entails pushing/pulling or arm and/or leg controls, or
- 3.2.3 The job requires working at a production rate – entailing the constant pushing and/or pulling of materials even though the weight of the materials is negligible.

Note: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be physically demanding of a worker even though the amount of force exerted is negligible.

3.3 Medium physical work

Exerting 9kg to 22kg of force occasionally and/or 4.5kg to 11kg of force constantly to move objects. Physical demand requirements are in excess of those of light work.

3.4 Heavy physical work

Exerting 22.5kg to 45kg of force occasionally, and/or 11kg of force frequently, and/or 4.5kg to 9kg of force constantly to move objects. Physical demand requirements are in excess of those of medium work.

3.5 Very heavy physical work

Exerting in excess of 45kg of force occasionally and/or in excess of 9kg of force constantly to move objects. Physical demand requirements are in excess of those of heavy work.

4. ENVIRONMENT

The environment in which the claimant performed his duties is an important aspect in the assessment of his claim for total and permanent disability benefits. Key elements that will be taken into account include the type of environment i.e. a workshop, production area, plant, laboratory, office, shaft, stope, etc. Environmental factors i.e. uneven surfaces, even surfaces, heights, etc. are also taken into consideration.



GUIDELINE FOR MEDICAL SPECIALIST/PHYSICIAN (CONTINUED)

Please note that the onus is on the claimant to prove the disability, therefore the responsibility for the cost of the consultation and medical reports rests with the claimant.

These guidelines should be made available to the Specialist/Physician when the assessment team requests more reports.

5. Information required in Specialist/Physician Report

- 5.1 Specify **current diagnosis**.
- 5.2 Medical history and onset.
- 5.3 Mention all other medical conditions.
- 5.4 Clinical signs and symptoms.
- 5.5 Treatment/surgery received and compliance/results.
- 5.6 Current physical abilities and limitations:
 - 5.6.1 Reflexes
 - 5.6.2 Sensory and motor outfalls
 - 5.6.3 Mobility and transfers
 - 5.6.4 Range of motion
 - 5.6.5 Muscle strength
 - 5.6.6 Other relevant clinical tests
 - 5.6.7 Results of specialist investigations, x-rays, and blood tests confirming the diagnosis.
- 5.7 Cognitive/psychological functioning (if relevant).
- 5.8 Effect of physical limitations on his ability to perform his/her activities of daily living and independence in performing activities such as self care activities, driving and mobility.
- 5.9 Describe the patient's vocational ability regarding his/her **ability to perform his/her own and similar occupations in a specific environment**.
- 5.10 Specify any other secondary problems as a result of current diagnosis such as his state of mind and motivation.
- 5.11 Future treatment suggested and prognosis (has optimum functionality been obtained).

Please send your application form and required documents to : The Manager, MPF Management Services, P O Box 61172, Marshalltown, 2107



BANKING DETAILS

Industry Number								Reference Number							
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Title		Initials		Surname											
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Identity Number								Passport Number							
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Country Where Passport Was Issued				Gender (Please tick block)				Date Of Birth (YYYYMMDD)							
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Male <input type="checkbox"/>	Female <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

BANKING DETAILS

For reasons of security, the Funds recommend payment by direct deposit. Upon payment in terms of the above instructions, the Funds shall have no further liabilities to the member.

Name of account holder	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Bank	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Branch name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Account number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

ACCOUNT TYPE (Tick In Applicable Block)

Savings	<input type="checkbox"/>	Cheque	<input type="checkbox"/>	Transmission	<input type="checkbox"/>
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CREDIT CARD, POST OFFICE AND BOND ACCOUNTS ARE UNACCEPTABLE

CONTACT DETAILS

Home Tel No	Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Work Tel No	Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Fax No	Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cell No	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E-Mail	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Signature of Member

Date (YYYYMMDD)							
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please send your application form and required documents to : The Manager, MPF Management Services, P O Box 61172, Marshalltown, 2107