APPLICATION

FOR PERMANENT DISABILITY

DISABIL01

Please send your completed form to:

Email: info@sentinel.za.com

Hand in: at your nearest Client Service Centres situated in Sandton, Welkom, Klerksdorp, Carletonville and Witbank/Emalahleni.

Industry / Participant Number (Member)	Identity Number (Member)

IMPORTANT

In terms of the Funds registered Rules, a Disability Benefit (consisting of fund credit together with disability risk cover, if applicable) is: **Only payable as a monthly pension [from Sentinel Retirement Fund (the Fund)] and cannot be taken as a once off lump sum benefit.** Only a maximum of one - third of the capital value of my Vested Component may be commuted for a lump sum. I may elect to receive all or part of my Savings Component as a lump sum. **A disability benefit cannot be transferred to another Fund.**

If the Fund receives a **Retirement** or any type of **Withdrawal Benefit application form** from you, it will be accepted that you **do not want to claim a Disability Benefit** or that you **wish to cancel your application for a Disability Benefit** and that you will **not appeal** any Claims Committee decision regarding your application for disability benefits by submitting new medical evidence to the Fund in support of your Disability Application. Once a Retirement or any Withdrawal Benefit has been paid, no further benefits will be payable by the Fund **(Retirement and Withdrawal Benefits will not include any risk cover).**

This form is the first step in your application for a retirement disability benefit. Its purpose is to provide the Trustees with the necessary information and supporting evidence to consider the awarding of a risk benefit, which, if approved, will enhance your Fund Credit. Once the risk benefit has been approved, you will be required to complete an Application for a Retirement Disability Benefit, at which stage you may provide the Fund with your instructions on how you wish to structure your income, including any lump sum and annuity options available to you. Brochures explaining these options, as well as access to benefit counselling, are available to assist you in making an informed decision.

Certain participating **employers pay a "disability severance package benefit"** in the event of the Fund not finding a member totally and permanently disabled in terms of the Fund's Rules. **If you claim and receive this benefit from your employer and submit new medical evidence to the Fund in support of your Disability Application and this application is successful**, you may be legally liable to refund your employer the "disability severance package benefit "received as these benefits may be considered mutually exclusive from each other. Please consult with your employer in this regard.

Signature	Date
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Industry / Participant Number (Member)	Identity Number (Member)

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

1. If you previously received a disability benefit from Sentinel Retirement Fund, Mine Officials Pension Fund and/ or Mine Employees Pension Fund, you will not be able to apply for a disability benefit for the same medical condition, impairment or occupation as previously awarded.
2. If you are applying to be found disabled whilst in the service of a participating employer, your completed application form must be submitted to the Fund within 6 months of leaving service. The trustees can only condone a late application if you can prove you were medically incapacitated for the above period and that it was not possible to submit an application.
3. Please complete all applicable information.
4. The specialists, medical practitioner and occupational health medical practitioner (mine doctor) must read the guidelines.
5. Your employer must complete the declaration and the leave record.
6. Your medical practitioner must complete the attached medical declaration.
7. Your union or human resources department should be able to assist you with the following Acts and the implication thereof with regard to your disability
   - The Labour Relations Act (1995)
   - The Employment Equity Act (1998)
   - Code of Good Practice: Key Aspects on the Employment of People with Disabilities (2002)
   - The Promotion of Equality and Prevention of Unfair Discrimination Bill.
8. Attached to the application form is a guideline for the specialist/physician to utilise should the assessment team request further reports.

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Industry / Participant Number (Member)	Identity Number (Member)

IMPORTANT: DOCUMENTARY REQUIREMENTS CHECKLIST

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

1	A declaration by your employer (included in the application form).	
2	A detailed absentee record including sick leave for the past 24 months of service from the employer.	
3	A detailed job description in respect of your last occupation.	
4	A declaration by the Medical Officer at the employer (included in the application form).	
5	A medical report completed by a medical doctor who is currently treating, or who has previously treated you (included in the application form).	
6	An Occupational therapy report (Mine Functional capacity report and/or a Private Functional capacity evaluation).	
7	Two specialist reports with up-to-date functional information.	
8	Other relevant reports, e.g.: x-rays, blood tests, etc. (Used as supportive documents – HIV - CD4 count NB). PLEASE NOTE that additional reports applicable to your disability can be requested from you after your application has been screened by the Assessment Team.	
9	A copy of your updated record of service.	
10	All relevant RMA and/or Medical Bureau documents.	
11	A copy of your most recent certificate of fitness (if discharged, a certificate of your exit medical examination).	

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APPLICATION
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Industry / Participant Number (Member)	Identity Number (Member)

DISABILITY PROCESS

Member to:

Submit the fully completed application form plus all the necessary supporting documents.

Claims department will:

1. Scrutinising the claim by the disability department to confirm that the application is complete.
2. Communicate telephonic, per letter and/or email with the member, HR personnel, medical personnel, Medical Bureau, Rand Mutual regarding outstanding information.
3. Submit claim to the Occupational Health Consultant (OHNP) and Occupational Health Medical Practitioner (OHMP).
   - Receiving the recommendation from the Occupational Health Medical Practitioner.
   - Adding the recommendation from the Occupational Health Medical Practitioner to the claim.
4. Email the claim to the Occupational Health Consultant (OHNP).
   - Receiving the recommendation from the Occupational Health Consultant.
   - Adding the recommendation from the Occupational Health Consultant to the claim.
5. Communicate with the OHNP and OHMP if there are discrepancies in their recommendations.
6. Prepare the Claims Committee document.
7. Communicate the outcome of the meeting to the satellite/walk-in offices, call center, and payments department.
8. Communicate by letter to the Member about the Claims Committee's decision.

In some cases, the claim will be deferred for more information, this decision will be communicated to the member applying either electronically or by telephone.

WHAT HAPPENS IF MY DISABILITY CLAIM IS APPROVED?

You will be required to visit your nearest Client Service Centre or call the Client Contact Centre to receive benefit counselling by one of the Fund's trained and experienced Fund counsellors regarding your Pension Income Choice. Your benefit estimate will be discussed with you again.

You will also be provided with an Application for Disability Retirement.

Alternatively, the Application for Disability Retirement Form can be downloaded from the Fund's website.

Important: Once your disability claim is approved you are not allowed in terms of the Fund rules to transfer your fund credit and risk benefits to another financial institution.

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Industry / Participant Number (Member)	Identity Number (Member)

WHAT TO DO IF MY CLAIM IS NOT APPROVED?

The member can appeal against the outcome of the Claims Committee's decision by submitting a new medical report from a Specialist with new up-to-date functional information. That is:

- Information not previously submitted to the Fund.
- New functional information – functional information with regards to ability to perform own and similar occupations in a specific environment.

Or you can:

- Decide to retire – only if you qualify and are within 10 years of your Normal Retirement Age (NRA) as per your employer;
- Become a Paid-up member and leave your fund credit in the fund up until you require the funds;
- Transfer the fund credit to another financial institution to either a Preservation Fund or Retirement Annuity;
- Withdraw your fund credit and let it be paid into your bank account.

To do any of the above you are required to visit your nearest Client Service Centre or call the Client Contact Centre to receive benefit counselling regarding the options above available to you.

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Industry / Participant Number (Member)	Identity Number (Member)

TO BE COMPLETED BY THE MEMBER

A. PERSONAL DETAILS

Title	Initials	Surname

Full Names (First Two Names in Full)

1 | 2

Identity Number | Passport Number | Gender M F

Country where Passport was issued | Date of Birth Y Y Y Y M M D D

Language Preference–Home Language | English | Afrikaans | Sesotho | IsiZulu | Setwana | Xhosa

POSTAL ADDRESS

PO Box Number	Suburb, City or Town	Postal Code

RESIDENTIAL ADDRESS

House / Complex Number	Street Name

Suburb	City	Postal Code

CONTACT DETAILS

Home Tel No	
Work Tel No	
Cell No	
Email	

FRIEND / RELATIVE DETAILS

Title	Initials	Surname

Cell No	

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Industry / Participant Number (Member)	Identity Number (Member)

B. DETAILS OF MEDICICAL CONDITIONS

DETAILS OF YOUR GENERAL PRACTITIONER

Title	Initials	Surname

Tel No	
Cell No	

DETAILS OF YOUR SPECIALIST/PHYSICIAN

Title	Initials	Surname

Tel No	
Cell No	

Please state the nature of injuries, illness or any other causes of your disability:

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?	YYYYMMDD
From what date have you been totally disabled and unable to perform your normal occupational duties?	YYYYMMDD

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Industry / Participant Number (Member)	Identity Number (Member)

B. DETAILS OF MEDICICAL CONDITIONS - *CONTINUED*

Which of your normal duties **are you able** to perform?

Which are you **not able** to perform?

Are you able to manage your daily activities or to care for your personal needs? Y N

If no, what can you not do?

C. EMPLOYMENT DETAILS

Date of entry into the mining industry Y Y Y Y M M D D

Current/Previous Employer | Current/Previous Occupation

Department/ Division

If you are a non-contributory member of the Fund, please state your occupation at the time you became a non-contributory member:

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

Are you still employed? Y N | If no, date of discharge Y Y Y Y M M D D

Reasons for discharge

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Industry / Participant Number (Member)	Identity Number (Member)

C. EMPLOYMENT DETAILS - *CONTINUED*

Has your employer prior to discharge offered you alternative employment? Y N

If yes, what position was offered?

Date of new alternative employment YYYYMMDD

If not, reason why alternative employment was not offered?

Have you been transferred/placed on light duties due to your illness/medical condition? Never Temporary Permanent

Occupation after you were transferred or while on light duty?

Date of transfer/placed duty on light duty YYYYMMDD

Have you applied for any other work? Y N

Future occupation, should you be found permanently disabled?

D. JOB REQUIREMENTS

Describe your main functions or duties:

Work Environment: Underground Surface

Environment	Hrs/ day	Environment	Hrs/ day	Environment	Hrs/ day
Office		Plant		Underground (Developing)	
Laboratory		Workshop		Underground (Stopes)	
Production		Underground (Shaft)		Other	

Specify the physical demands of your job:

Physical Demands	Hrs/ day	Physical Demands	Hrs/ day	Physical Demands	Hrs/ day
Standing		Sitting		Climbing inclines	
Walking over even surfaces		Squatting		Crawling	
Walking over uneven surfaces		Climbing stairs		Lifting of heavy objects	

Industry / Participant Number (Member)	Identity Number (Member)

D. JOB REQUIREMENTS - *CONTINUED*

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, etc.):

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? Yes No

Describe:

Reasons why the reasonable accommodations (changes/adjustments) were unsuccessful:

APPLICATION
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Industry / Participant Number (Member)	Identity Number (Member)

D. JOB REQUIREMENTS - *CONTINUED*

EDUCATIONAL DETAILS

Highest standard passed		School		Year	

ALL TRAINING (Courses attended, certificates, diplomas, degrees, etc.)

Qualifications	Institution	Year

Experience in own occupation: Years

Specify any other experience in alternative occupations:

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Industry / Participant Number (Member)	Identity Number (Member)

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

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

Bureau number		Expiry Date	YYYYMMDD

Date of last benefit examination	YYYYMMDD

Have you been certified to suffer from a compensatable disease by the MBOD?		Y	N
Did you submit a letter as proof?		Y	N
If YES, to what degree?		1st	2nd
Do you suffer from any other lung disease?		Y	N

Please Specify:

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.)

VERY IMPORTANT

A copy of a letter from Rand Mutual Assurance confirming this information must be provided.

THE CLAIMS COMMITTEE CANNOT CONSIDER YOUR APPLICATION WITHOUT THIS INFORMATION

Date of accident	YYYYMMDD	Place of accident (Mine)	
Date of accident	YYYYMMDD	Place of accident (Mine)	
Date of accident	YYYYMMDD	Place of accident (Mine)	

Type of claim:	Noise induced hearing loss		Dermatitis		Other	

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Industry / Participant Number (Member)	Identity Number (Member)

F. MINE ACCIDENT - *CONTINUED*

Description of claim (what happened?)

Nature of injuries (provide a full breakdown)

Was the accident reported to your employer? Y N

If not, why?

Has Rand Mutual Assurance accepted liability? Y N

Has Rand Mutual Assurance finalised the claim? Y N

Did you submit a letter as proof? Y N

If not, when will the claim be finalised?

Claim Number

The percentage of permanent disablement awarded? %

Date when this was awarded: YYYYMMDD

Date when award was paid to you: YYYYMMDD

Industry / Participant Number (Member)	Identity Number (Member)

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.

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

Date of accident	Y Y Y Y M M D D	Place of accident	

Description of accident	

Has the Compensation Commissioner accepted liability?	Y	N
Has the claim been finalised?	Y	N

If not, when will the claim be finalised				
Claim Number		The percentage of permanent disablement awarded?		%

Date when this was awarded:	Y Y Y Y M M D D
Date when award was paid to you:	Y Y Y Y M M D D

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Industry / Participant Number (Member)	Identity Number (Member)

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

APPLICATION
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Industry / Participant Number (Member)	Identity Number (Member)

MEMBER CONSENT TO OBTAIN PERSONAL INFORMATION

Title	Initials	Surname

Full Names (First Two Names in Full)

1		2	

CONTACT DETAILS

Home Tel No	
Work Tel No	
Cell No	
Email	

I herewith give consent to Sentinel Retirement Fund or any person delegated by it to do so, to contact and obtain relevant information form:

		Member Number / Contact Person
☐	**Rand Mutual Assurance Company**	
☐	**The Medical Bureau for Occupational Diseases**	
☐	**My Employer**	
☐	**Fellow Employees**	
☐	**Family Members**	
☐	**Union Association**	
☐	**Medical Officer**	
☐	**Any Other Person or Institution**	

This information is deemed necessary for purposes of consideration of my application for disability benefits in terms of the Fund's Rules.

Declaration

- I hereby waive any right to privacy only for the stated purpose. All information so obtained must be treated as confidential by the authorised user(s) and may not be made public in any way without my/our written consent.
- 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 Sentinel Retirement Fund.

Signature	Date
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Industry / Participant Number (Member)	Identity Number (Member)

TO BE COMPLETED BY THE EMPLOYER'S HR DEPARTMENT

DECLARATION BY EMPLOYER

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 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 last permanent position:		Department:	

Section/environment where the employee performed his duties:	
State previous positions held by employee at your company:	
Has the employee been accommodated in another position due to his/her medical condition?	Yes / No
If Yes state position:	
Please provide us with a date when the position was offered/taken up by the member	YYYYMMDD
Were any reasonable accommodations (changes/modification to work) offered to the employee?	
Reason, if any, why the workplace accommodations were not offered or were not successful:	
State the main job functions of the employee's last permanent occupation:	
List the functions the employee is unable to perform:	

What environmental factors with regard to the employee's job functions prohibit him from performing his duties?

APPLICATION
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Industry / Participant Number (Member)	Identity Number (Member)

TO BE COMPLETED BY THE EMPLOYER'S HR DEPARTMENT *(CONTINUED)*

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

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

Work Environment:	Underground	Surface

Environment	Hrs/ day	Environment	Hrs/ day	Environment	Hrs/ day
Office		Plant		Underground (Developing)	
Laboratory		Workshop		Underground (Stopes)	
Production		Underground (Shaft)		Other	

IDENTIFY THE PHYSICAL ACTIVITIES THE EMPLOYEE PERFORMED DURING A TYPICAL WORKDAY:

0 = No exposure	1 = Low exposure	2 = Medium exposure	3 = High exposure

Physical Demands	Hrs/ day	Physical Demands	Hrs/ day	Physical Demands	Hrs/ day
Walking		Squatting		Use of left hand	
Balancing		Sitting		Use of right hand	
Crawling		Lifting		Use of both hands	
Climbing		Pulling		Feeling	
Kneeling		Pushing		Handling	
Standing		Carrying		Physical endurance	
Stooping		Holding		Psychological endurance	

DETAILS OF DISABILITY

On what date did the employee become disabled?	YYYYMMDD
What was/is the cause?	
Is the employee in your opinion totally and permanently disabled and unable to follow his/her normal duties?	Yes / No
If yes, please five full details	

Industry / Participant Number (Member)	Identity Number (Member)

J. DECLARATION BY EMPLOYER (To be completed by HR Department) *CONTINUED*

Was the accident reported?	Yes	No
If yes, please supply claim number:		
If no, please specify details why not:		
Do you expect the employee to resume his/her normal occupation?	Yes	No
If no, will your company continue to employ him/her?	Yes	No
If yes, in what capacity?		
Do you expect the employee to be able to follow any other occupation?	Yes	No
If yes, please specify such occupations:		

TERMINATION OF EMPLOYEMENT

When did/will you terminate the employee's employment?	
What is the full reason for this (medical, retrenchment, other)?	

ABSENTEEISM RECORD

Last day at work (prior to disability now under consideration):	
Days absent from work in the last 24 months (two years):	

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Industry / Participant Number (Member)	Identity Number (Member)

ABSENTEEISM RECORD *(CONTINUED)*

IMPORTANT: IF YOU HAVE PROVIDED A PRINTOUT OF YOUR SICK LEAVE TO THE EMPLOYER, THE EMPLOYER MUST INDICATE WHAT THE DIFFERENT CODES MEAN ON THE REPORT

Date from	Date to	Number of working days	Type of leave reason (annual, sick, accident, unpaid etc.)
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
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YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		

Industry / Participant Number (Member)	Identity Number (Member)

J. DECLARATION BY EMPLOYER (To be completed by HR Department) *CONTINUED*

DECLARATION BY EMPLOYER:

Name of Employer	

DETAILS OF CONTACT PERSON AT EMPLOYER:

Title	Initials	Surname
Qualifications:		

Tel No.		Alternative No.	
Fax No			
Email			

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 in respect of this claim.

Signature	Date
Electronic signatures are not permitted to be used on this Application Form.	Y Y Y Y M M D D

APPLICATION
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Industry / Participant Number (Member)	Identity Number (Member)

K. 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		Date of last examination		Expiry Date	
Restrictions, if any:					

What, in your opinion, has been the underlying cause of this condition?

In your opinion, is there functional impairment due to the disease/illness or medical condition — Yes / No

If yes, please provide full details:

DETAILS OF OCCUPATIONAL HEALTH MEDICAL PRACTITIONER:

Title	Initials	Surname

Designation:

Tel No.		Alternative No.	
Fax No			
Email			

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 in respect of this claim.

Signed on this ____ Day of ____ 2 0 ____ at ____

Signature

Electronic signatures are not permitted to be used on this Application Form.

Date

Y Y Y Y M M D D

Industry / Participant Number (Member)	Identity Number (Member)

TO BE COMPLETED BY THE MEDICAL PRACTITIONER

L. MEDICAL REPORT 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
Identity Number | Passport Number		

DETAILS OF 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:	
Please give a full description of the patient's present physical/mental state:	
Has the maximum medical improvement been reached?	Yes / No
If no, please give details:	

Industry / Participant Number (Member)	Identity Number (Member)

L. MEDICAL REPORT FOR A DISABILITY CLAIM *(CONTINUED)*

What is the long-term prognosis?

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 with regards to daily living?

Industry / Participant Number (Member)	Identity Number (Member)

L. MEDICAL REPORT FOR A DISABILITY CLAIM *(CONTINUED)*

DECLARATION BY DOCTOR:

Title	Initials	Surname

Qualifications	

Home No.		Mobile.	
Work No		Fax	
Email			

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 in respect of this claim.

Signed on this		Day of		2	0		at	

Signature	Date
Electronic signatures are not permitted to be used on this Application Form.	Y Y Y Y M M D D

Sandton: 5th Floor, 92 Rivonia Road, Wierda Valley, Sandton, 2196 | **Toll-Free** 0800 776 861
Carletonville: S Buys Office Park, Shop 10, Corner Kaolin and Radium Streets, Tel (011) 481 8290/1
Klerksdorp: 54 Buffelsdoorn Road, Flamwood, Tel (011) 481 8024/8 | **Welkom:** Shop 25, The Strip, 314 Stateway, Tel (011) 481 8025/6
Emalahleni / Witbank: WCMAS Building, Corner OR Tambo and Susanna Streets, Tel (011) 481 8295/6

Industry / Participant Number (Member)	Identity Number (Member)

GUIDELINE FOR MEDICAL SPECIALIST/PHYSICIAN

These guidelines should be made available to the medical practitioner who identified your permanent medical impairment or 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 state 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 4.5 kg 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 9 kg of force occasionally; and/or up to 4.5 kg 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 9 kg to 22 kg of force occasionally and/or 4.5 kg to 11 kg of force constantly to move objects. Physical demand requirements are in excess of those of light work.

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GUIDELINE FOR MEDICAL SPECIALIST/PHYSICIAN *(CONTINUED)*

3.4 Heavy physical work
Exerting 22.5 kg to 45 kg of force occasionally, and/or 11kg of force frequently, and/or 4.5 kg to 9 kg 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 45 kg of force occasionally and/or in excess of 9 kg 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.

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

These guidelines should be made available to the medical practioner who identified your permanent medical impairment or to the Specialist / Physician when the assessment team requests more reports.