MOTOR INDUSTRY RETIREMENT FUNDS

NOTES ON COMPLETION OF THE ILL HEALTH BENEFITS FORM

Original completed application forms with all supporting documentation must be submitted via your local MIBCO office.

REGION	PHYSICAL ADDRESS	CONTACT NUMBER
Eastern Cape, PO BOX 7270, Port Elizabeth, 6055	55 Newton Street, Newton Park, Port Elizabeth	(041) 393 3600
KZN PO BOX 10230, Ashwood, 3605	10 A Caversham Road, Hagart Road Industrial, Pinetown	(031) 274 0644
Free State, PO BOX 22887, Bloemfontein, 9313	26 Lombard Street, Hilton, Bloemfontein	(051) 409 4001
Highveld, PO BOX 2578, Randburg, 2125	1st Floor, 275 Kent Avenue, Ferndale, Randburg	(011) 369 7750
Northern Region, PO BOX 13970, Hatfield, 0028	Primo Building, 2nd Floor, Hatfield Square, 1119 Burnett Street, Hatfield, Pretoria	(012) 364 4800
Western Cape, PO BOX 17, Bellville, 7535	3 Tyger Terrace, off Bellville Business Park, & DJ Wood Street, Mike Pienaar Boulevard, Bellville	(021) 941 7300
Mibco national number		086 166 4226

Please note: **1.** 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 or both sides of the ID card **(Certified only at a Police Station or Court)**
- ☐ 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)

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

- ☐ Supporting medical and doctors' reports

Retirement funds that deliver

ILL HEALTH BENEFITS

Please complete the forms in block letters by providing the information that is requested. Where applicable please place a X in the correct box.

01

SECTION A

AUTO WORKERS PROVIDENT FUND ☐ **OR** MOTOR INDUSTRY PROVIDENT FUND ☐

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

if Divorced, we require divorce degree plus statement.

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. ______________________________

Emailaddress______________________________

Income tax ref number ______________________________

ILL HEALTH BENEFITS

Please complete the forms in block letters by providing the information that is requested. Where applicable please place a X in the correct box.

MEMBER BANKING DETAILS

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

Identity Number: ______________________________

Account Holders name : ______________________________

Name of Bank: ______________________________

Branch Code: ______________________________

Account number: ______________________________

Type of account: ☐ savings ☐ current ☐ 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

ILL HEALTH BENEFITS

Please complete the forms in block letters by providing the information that is requested. Where applicable please place a X in the correct box.

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: ______________________________

Contributions paid until last day of employment yes ☐ no ☐

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

Please attache relevant documentation

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: ______________________________

EMAIL ADDRESS: ______________________________

DATE D D M M Y Y Y Y

COMPANY STAMP

EMPLOYER SIGNATURE: ______________________________

ILL HEALTH BENEFITS

Please complete the forms in block letters by providing the information that is requested. Where applicable please place a X in the correct box.

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

Title Mr. ☐ Mrs. ☐ Ms. ☐ Member's Council number: ____________

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 - RECEIVING FUND DETAILS:

Full name of the Fund: ____________

Policy Number: ____________

SARS Approved Number 18/20/4: ____________ FSB Registration Number: ____________

Type of Fund: Pension ☐ Provident ☐ Retirement Fund ☐ Life Annuity ☐ Other ☐

Please Specify ____________

3. BANKING DETAILS: RECEIVING FUND DETAILS

Name of account holder: ____________

Bank: ____________ Branch Number: ____________ Branch: ____________

Account number: ____________

Type of account: Savings ☐ Cheque ☐ Other ☐

Reference to be used for deposit: ____________

4. PARTICULARS OF CONTACT PERSON OF THE RECEIVING FUND

Initials and Surname: ____________

Contact details: Telephone: ____________ Fax: ____________

Email: ____________

I ____________ the undersigned, declare on behalf of the ____________ (name of the receiving fund) on receipt of the transfer from the Motor Industry Fund Administrators, agrees to apply this towards pension/provident/single premium annuity for the above member.

Signed at ____________ on this ____________

Day of ____________ 20____________

COMPANY STAMP

PLEASE NOTE: PLEASE COMPLETE SECTION D(1)

ILL HEALTH BENEFITS

Please complete the forms in block letters by providing the information that is requested. Where applicable please place a X in the correct box.

SECTION D (1)

RECOGNITION OF TRANSFER BETWEEN APPROVED FUNDS

5. 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: From | D | D | M | M | Y | Y | Y | Y |

   To | D | D | M | M | Y | Y | Y | Y |

Signed at ________________________ on this ________________

Day of ________________________ 20________________

____

SIGNATURE

COMPANY STAMP

6. 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________________

COMPANY STAMP

____

SIGNATURE

PLEASE NOTE: PLEASE COMPLETE SECTION D(2)

ILL HEALTH BENEFITS

Please complete the forms in block letters by providing the information that is requested. Where applicable please place a X in the correct box.

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 balance 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

ILL HEALTH BENEFITS

Please complete the forms in block letters by providing the information that is requested. Where applicable please place a X in the correct box.

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: ___________________________

ID number: ___________________________ Age now in years ______________ Months: ______________

RESIDENTIAL ADDRESS: Unit nr: ___________________________

Complex name: ___________________________

Street nr: ___________________________

Street name/Name of farm: ___________________________

Suburb/District: ___________________________

City/Town: ___________________________

Postal code: ___________________________

POSTAL ADDRESS: ___________________________

____

___________________________ Code: ______________

Contact No. ___________________________ Cell No. ___________________________

Email address ___________________________

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

____
Contact Details 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."

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 __________% Cramped/Confined _________%

Kneeling _________% Crouching ___________% Climbing _________%

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: ______

______

11. [b]Your views on patient's compliance with treatment: ______

______

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

Please motivate ______

______

ILL HEALTH BENEFITS

Please complete the forms in block letters by providing the information that is requested. Where applicable please place a X in the correct box.

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 permanently / 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