



**TRANSPORT SECTOR RETIREMENT FUND
DISABILITY CLAIM**



CONFIDENTIAL MEDICAL REPORT

To be completed by the attending physician

Dear Member

Please request your attending physician to complete this Confidential Medical Report as required by the Transport Sector Retirement Fund ("Fund"). You will be responsible for paying the physician for completing the medical report(s). In an instance where a specialist is not consulted, a report from the attending physician or general practitioner will be accepted but may result in further medical evidence being requested.

A. MEMBER DETAILS

Surname of Member											
First Names of Member											
Date of Birth	D		M	M	Y	Y	Y	ID/Passport No			
Gender (Female/Male)						Employee Number					
Current Employer											

D. IMPAIRMENT DETAILS AND HISTORY

Member's height in cm						Member's weight in kg													
Date of first consultation	D		M	M	Y	Y	Y	Date of last consultation											
On what date did the first symptoms of the condition claimed for, appear?																			
If you are still attending to the member, when was the last consultation?																			
When was the member's last day at work / date of disability?																			

Please complete the information below:

Date	Reason for consultation	Diagnosis	Treatment	Result / Prognosis

Have clinical investigations been performed to determine the condition? Yes No

If yes, comment on the results of all tests / examinations performed to confirm diagnosis (please include copies)

How has the member's condition been treated over the past 12 months? (Discuss treatment regimen prescribed)

Date	Treatment (medication and dosage)	Outcome

Is future surgery / treatment planned? (if applicable) Yes No

If yes, what type of surgery / treatment and when?

Notwithstanding the treatment regimen described above, and the envisaged cost thereof, what further treatment would you recommend improving the member's condition and / or activities of daily living?

Please provide a full description of any related conditions that the member has

Please provide a full description of any related symptoms that the member has

Do you know of any other factors (e.g. previous illness or injury, hazardous pastimes or pursuits, habits or self inflicted injuries) that may have contributed in any way to the member's impairment?

If 'Yes', please comment fully

In your opinion, when will the member be able to go back to work?

Part-time	Date	D	D	M	M	Y	Y	Y	Y	Duties	
Full-time	Date	D	D	M	M	Y	Y	Y	Y	Duties	

If the member has already recovered and returned to work, please give the date of his / her return to work

Please provide any additional information which you feel will assist the Fund in the assessment of this claim (if there is not enough space provided on this form, please continue on a separate sheet)

Have you included copies of all tests and reports?

Yes

Additional comments

E. DETAILS OF ATTENDING PHYSICIAN

Attending Physician's Name			
Attending Physician's Surname			
Attending Physician's Physical Address		Country	Code
Attending Physician's Postal Address		Country	Code
Attending Physician's Cell Phone Number		Attending Physician's Tel. No	
Attending Physician's Email Address		Attending Physician's Fax No	
Attending Physician's Qualifications			

ATTENDING PHYSICIAN'S DECLARATION

Notes:

In some instances, further documents and /or information may be required to determine the validity of a claim. All documents required in the claim notification must be submitted and failure to do so timeously, may result in claim payments being delayed and / or Disability risk benefit claims being declined. Disability Claims are assessed on receipt of complete documentation, including the fully completed Confidential Medical Report, and failure to do so, will result in the delay of processing the claim.

I. SUBMISSION DETAILS

Claim Type	Electronic	Fax	Telephone Enquiries	Physical address
Disability	members@tsrf.salteb.co.za	011 544 8302	011 544 8300	SALT Employee Benefits (Pty) Ltd Hertford Office Park. Building B, Bekker Rd, Vorna Valley Midrand, 1685.

SALT Employee Benefits (Pty) Ltd, an authorised Financial Services Provider in terms of the Financial Advisory and Intermediary Services Act 37, of 2002 ("FAIS Act") with FSP Number 18929 is the appointed administrator to Transport Sector Retirement Fund. SALT Employee Benefits is committed to compliance with the requirements prescribed in the FAIS Act. All disclosures are available on request.