

**MINEWORKERS
PROVIDENT FUND**



DISABILITY CLAIMS HANDBOOK

Guidelines for the submission and assessment of disability claims



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When is a member regarded as disabled?

A member will be regarded as disabled in either of the following two scenarios:

1. Injury or disease prevents him from being able to engage for remuneration or profit in his own occupation or another suited occupation with his employer.

The member's own occupation is regarded as the occupation he was employed in at his date of disablement. If a member's employment duties were changed to accommodate his disability and he has been capably performing those duties for 6 months or more, these duties will be regarded as his normal employment duties.

To determine whether the member is able to engage in another suited occupation, the assessor will consider his education, training, knowledge and experience.

2. The member no longer meets the minimum standards of fitness to perform work at a mine per the mandatory code of practice.

The date of disablement is determined based on the evidence at hand. This evidence may include:

- medical evidence
- details of the member's occupation
- the member's work history
- the definition of disability outlined in the policy
- The employer's code of practice, the Mine Health and Safety Act and the Occupational Health and Safety Act.

When to consider submitting a claim

A claim should be submitted when the employer:

- Notices that the employee has been absent from work for an extended period of time (e.g. more than two consecutive weeks) due to injury or illness.
- Notices that an employee is not coping with the requirements of their occupation due to injury or illness. This can include an injury on duty.
- Learns that an employee is not likely to return to work or is not likely to be able to cope with the duties of their occupation after an injury or illness. This can include an injury on duty.
- Finds that the employee fails to meet the standards of fitness as per the Mine Health and Safety Act due to a medical condition, and this medical condition is unlikely to improve such that the member would later meet the standards of fitness again.

Deadline for the submission of a claim

It is important that the Mineworkers Provident Fund be advised of a potential claim as soon as possible. As soon as MWPF has been notified of a potential claim, we will be able to assist with the processing of the claim by advising the employer whether any specific medical assessments or tests are required or whether a specific medical practitioner needs to be consulted. This could prevent unnecessary delays.

The claim documents must be received within 6 months of the employee being unable to perform the duties of his own occupation as a result of injury or disease.

Roles of the employer, employee, MWPF and Assessor in the claims process

The employer

As proactive claims management is a means of containing costs, it is imperative that the claims process should start as early as possible. If an employee becomes impaired due to an injury or disease and is incapable of performing the majority of his normal duties, or has been absent from work for longer than ten working days, the employee's line manager must inform the designated head within the company.

A potential claim must be lodged with the fund as soon as possible so that the assessor can be notified of the potential claim.

The designated authority should then liaise with the employee and Occupational Health Practitioner in order to gather all required claim documents. The employer may need to assist the employee with completing the Mineworkers Lump Sum Disability Claim Form and with obtaining the necessary medical evidence from the employee's treating doctor.

The Occupational Medical Practitioner also needs to complete the Mineworkers Lump Sum Disability Claim Form and must provide all supporting medical evidence including diagnostic test results and copies of historical periodic medicals and fitness certificates.

All documentation should be submitted to the fund as soon as possible. The fund will then forward all documentation on to the assessor.

In summary, the required documents include:

- Mineworkers Lump Sum Disability Claim form completed by the employee and Occupational Medical Practitioner (OMP)
- Confidential Medical Report form from the employee's treating doctor
- Supporting diagnostic test results from both the treating doctor and OMP.
- Copies of current and historic periodic medicals and certificates of fitness from the OMP

- Copy of the employee's payslip as at their date of disability.
- Copy of the employee's leave records for the 2 year period before their date of disability.

We know it takes time to gather all required documentation. In the interim, the employer can complete and submit the Mineworkers Potential Disability Claim Notification form in order to notify the assessor of the potential claim.

The employee

When an employee has been affected by injury or disease to such an extent that he is incapable of performing the majority of his normal duties, he should discuss the problem with his immediate line manager as soon as possible. An appointment must be made with his or her treating doctor and with the employer's Occupational Medical Practitioner in order for the required medical evidence to be obtained and submitted in support of the claim. Please refer to the comments under the heading "The employer" for the information that is required.

The Mineworkers Lump Sum Disability Claim Form must be completed by the employee.

The Mineworkers Provident Fund

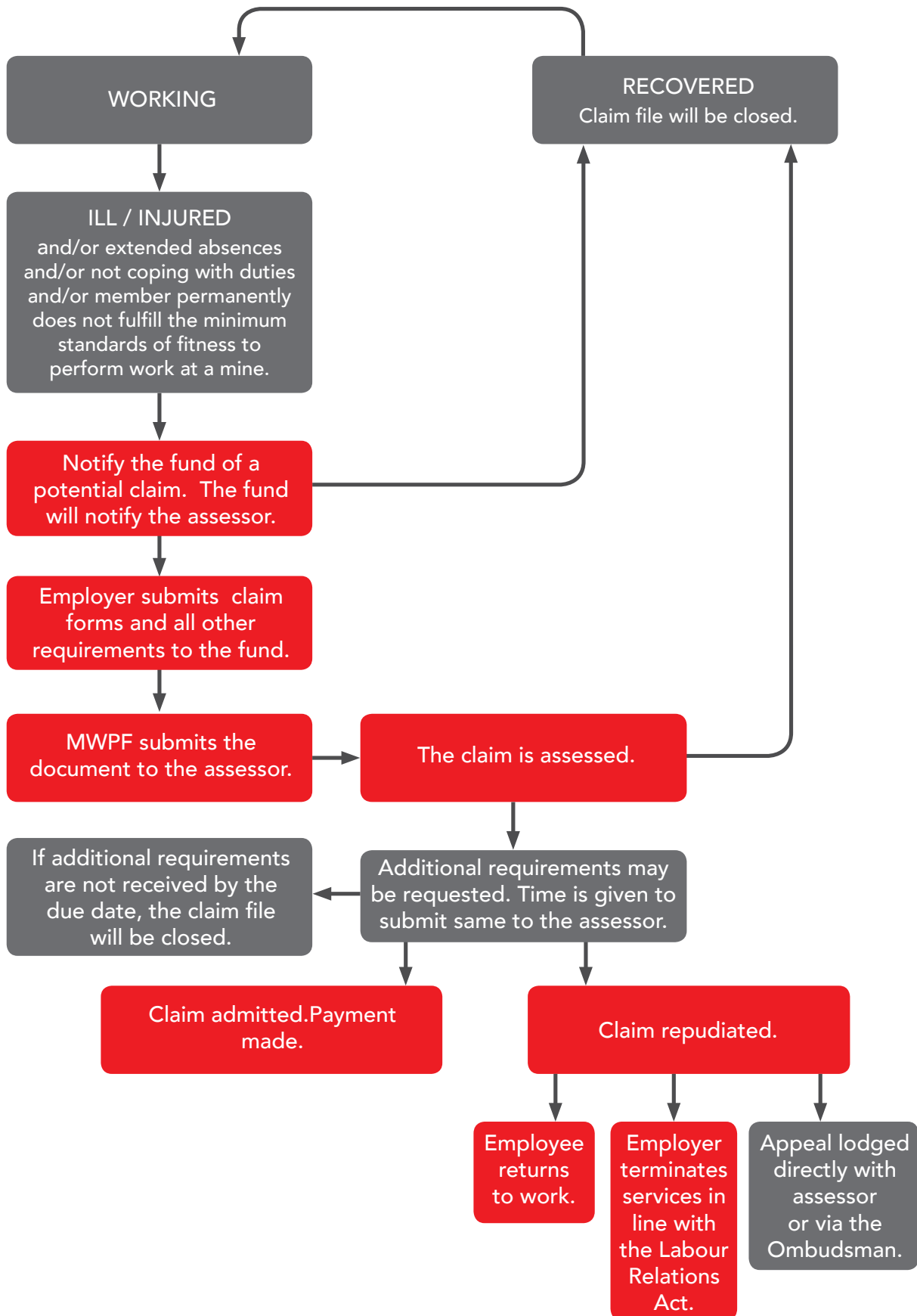
As soon as the fund becomes aware of a potential claim, they will notify the assessor so that the assessor can advise regarding all outstanding information in order to assess the claim.

Assessor

The assessor will assess the claim and notify the client of decisions made. The comprehensive assessment process includes consultation with medical professionals and requesting further information where necessary, and the process as indicated by the flow chart (on the following page) is followed.

If a claim is declined it will be reassessed on request. A dispute team assesses contentious claims.

Flow chart of disability claims process



Forms and documentation required when submitting a claim



Initial notification

Because it can take some time to gather all the information required for a formal claim submission, employers can notify the fund by completing and submitting the short Mineworkers Disability Claim Potential Claim Notification form before all other required documentation is ready.

Formal claim submission

In addition to assessing the extent of the employee's disability, the claims consultant must ensure that the claim complies with certain contractual criteria. The following information is required when a claim is submitted:

Documentary evidence:

- Mineworkers Lump Sum Disability Claim form completed by the employee. This form enables the employee to provide the assessor with details of all medical practitioners consulted. These details may be used to contact them to attain further information.

The declaration must be signed as this gives the assessor the authority to obtain medical evidence from other sources to assist with the assessment.

- Copy of the employee's latest ID document. If using the new ID card, a copy of both the front and back is required. A copy of passport will be accepted in the case of non SA citizens only.
- Copy of the employee's leave records for the 2-year period leading up to the employee's last active date of service.

- Copy of the employee's payslip for the month in which he/she was last able to perform his or her normal full time employment duties.

Medical evidence:

- Mineworkers Lump Sum Disability Claim Form, needs to be completed and signed by both the member and the Occupational Medical Practitioner.
- Confidential medical report completed by the employee's treating general practitioner and/ or specialist (where required).
- Copies of all supporting diagnostic test results.
- Copies of current and historic periodic medicals and fitness certificates.

The claimant or employer is responsible for the cost of all medical evidence submitted in support of the claim.

Delays in the successful conclusion of a claim are as a result of incomplete or incorrect information, as outstanding information is then requested.

The information listed here is a vital link in the assessment process and forms the basis on which the claim is assessed. As such, it warrants careful consideration. Every effort should be made to ensure that the information given is complete and accurate. Any misstatement could be used as a basis for the repudiation of a claim.

We are committed to assessing the validity of disability claims submitted.

Frequently asked questions (FAQs) and answers

We are committed to assessing the validity of disability claims submitted. The following general information is intended as a guide to the benefits, requirements and terms and conditions relating to disability claims. It does not override the provisions of the specific policy in place.

This information should therefore be read in conjunction with the policy document. If any information contained in this guide is different from that set out in the specific policy in place, the policy rules and conditions will apply.

Who pays for the medical evidence?

The member/employer is required to pay for the medical evidence and supporting diagnostic test results submitted in support of the employee's claim because the responsibility rests with employees to prove their inability to work. However, if the assessor requires, for example, a second opinion on the medical evidence prior to finalising the assessment of the claim, we will pay for this additional medical evidence. This will be communicated in writing.

Who determines the date of disability?

The employee's date of disability is determined by the assessor who will examine evidence such as – but not limited to – medical reports, details of the employee's occupation and the relevant definition of disability outlined in the policy.

Can the employer continue payment to the employee during the waiting period?

We do not prescribe any rules regarding whether or not an employer can/must continue paying the employee a salary during the waiting period. This is entirely at the employer's discretion.

What is the difference between medical boarding and occupational disability?

The disability benefit products offered by the assessor are occupational disability benefit products. As such, the assessor not only considers the details of the employee's injury or illness, but also the impact of such injury or illness on the employee's ability to continue working in his insured occupation. This assessment is done in line with the particular disability product in place and the definition of disability outlined in the relevant policy document.

The employee's treating doctor may recommend that the employee be medically boarded or placed on disability benefits based on the employee's medical condition. It should be noted that although a doctor has recommended that the employee be placed on disability benefits, the employee may not be eligible for receipt of benefits when assessed as we assess the claim in the context of his insured occupation and the disability benefit product and policy in place.

What medical treatment is required?

The assessor requires that a disability claimant adhere to reasonable optimal treatment in order for the disability claim to be considered valid, because adherence to reasonable optimal treatment could alleviate the medical condition giving rise to the claim and therefore alter the outcome of the claims assessment.

Reasonable optimal treatment is determined on a case-by-case basis taking into account the employee's medical condition and the circumstances surrounding the particular claim.

What does the pre-existing condition exclusion mean?

In broad terms, if a member submits a claim for a disability benefit during the first year of insuring their disability benefit, the claim may be declined if there is evidence to support that the member is submitting a claim as a result of a medical condition

that existed prior to their cover commencing.

What are the turnaround times?

Once documentation has been submitted to the assessor, we will respond within ten working days with either our decision or with correspondence advising of further required information.

Once a claim has been admitted, our payment department has ten working days in which to process payment of the benefit, provided they have all necessary documentation in order to facilitate same.

Who receives the benefit payment once it has been processed?

Benefits are paid to the fund for onward transmission to the employee.


What if I want to appeal a decision regarding my claim?


Should the employee or his representative wish to appeal the decision on a claim, the claim will be reassessed upon receipt of further medical evidence in support of such claim. The assessor employs a process whereby we ensure that an assessment is conducted by another member of the multidisciplinary team should the original assessor remain of the same opinion on the claim following perusal of information submitted in support of the appeal. This ensures a fair and unbiased reassessment of the claim.

Alternatively, the employee or the his representative can contact the Ombudsman for Long-term Insurance per telephone at 0860 103 236 or 021 657 5000 or per email to info@ombud.co.za

Contact Details


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