APPLICATION FOR PERMANENT DISABILITY

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. Please complete all applicable information.
3. The specialists, medical practitioner and occupational health medical practitioner (mine doctor) must read the guidelines.
4. Your employer must complete the declaration and the leave record.
5. Your medical practitioner must complete the attached medical declaration.
6. 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.
7. Attached to the application form is a guideline for the specialist/physician to utilize should the assessment team request more reports.

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

1.	A completed retirement benefit application and nomination form.	☐
2.	A declaration by your employer (included in the application form).	☐
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 certificate completed by a medical doctor who is currently treating, or who has previously treated you (included in the application form).	☐
6.	Two specialist reports with up to date functional information.	☐
7.	Any medical reports in your possession relevant to the claim. **PLEASE NOTE that additional reports applicable to your disability can be requested from you after your application has been screened by the Assessment Team.**	☐
8.	A copy of your updated record of service.	☐
9.	All relevant RMA and/or Medical Bureau documents.	☐
10.	A copy of your most recent certificate of fitness (if discharged, a certificate of your exit medical examination).	☐

SENTINEL
Retirement Fund

APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

A. PERSONAL DETAILS

Industry Number								Reference Number								

Title			Initials				Surname																					

Identity Number													Passport Number															

Country Where Passport Was Issued										Gender (Please tick block)				Date Of Birth (YYYYMMDD)							
										Male		Female		Y	Y	Y	Y	M	M	D	D

ADDRESS DETAILS

POSTAL ADDRESS

P O Box Number					Suburb, City or Town																								Postal Code			

RESIDENTIAL ADDRESS

Street Number					Street Name																										

Suburb, City or Town																														Postal Code			

CONTACT DETAILS

Home Tel No.	Code									Number																			
Work Tel No.	Code									Number																			
Fax No.	Code									Number																			
Cell No.										Number																			
E-Mail.																													

FRIEND / RELATIVE DETAILS

Title			Initials				Surname																								
Telephone No	Code									Number																			

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Retirement Fund

APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

B. DETAILS OF MEDICAL CONDITIONS

DETAILS OF YOUR GENERAL PRACTITIONER			
Initials and Surname		Telephone Number	

DETAILS OF YOUR SPECIALIST/PHYSICIAN			
Initials and Surname		Telephone Number	

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?	
From what date have you been totally disabled and unable to perform your normal occupational duties?	
Which of your normal duties <u>are you able</u> to perform?	
Which are you <u>not able</u> to perform?	

Are you able to manage your daily activities or to care for your personal needs? (Please tick block)	Yes		No	
If no, what can you not do?				

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APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

C. EMPLOYMENT DETAILS

Date of entry into the mining industry (YYYYMMDD)	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? (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 position 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 you were transferred or while on 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			Plant			Underground (Developing)		
Laboratory			Workshop			Underground (Stopes)		
Other			Production			Underground (Shaft)		

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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			Sitting			Climbing inclines		
Walking over even surfaces			Squatting			Crawling		
Walking over uneven surfaces			Climbing stairs			Lifting of heavy objects		

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? (Please tick block)	Yes		No	
Describe:				

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APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

D. JOB REQUIREMENTS (CONTINUED)

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

EDUCATIONAL DETAILS

Highest standard passed		School		Year	

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

Qualifications	Institution	Year

Years experience in own occupation:		Years

Specify any other experience in alternative occupations:	

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APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

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	Y Y Y Y M M D D
Date of last benefit examination	Y Y Y Y M M D D		

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:	

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	Y Y Y Y M M D D	Place of accident (Mine)	
Date of accident	Y Y Y Y M M D D	Place of accident (Mine)	
Date of accident	Y Y Y Y M M D D	Place of accident (Mine)	

Type of claim: (Please tick appropriate block)	Noise induced hearing loss	
	Dermatitis	
	Other	

Description of claim (what happened?)	

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APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

F. MINE ACCIDENT (CONTINUED)

Nature of injuries (provide a full breakdown)	

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 of permanent disablement awarded?	%

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

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?		Yes		No
Has the claim been finalised?		Yes		No

If not, when will the claim be finalised?	

Claim Number		The percentage of permanent disablement awarded?	%

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

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.

Consent

I, _____ (Please print initials and Surname) the undersigned, hereby give my unconditional consent that the Sentinel 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 Sentinel Retirement Fund.

Signed on this			Day of		2	0			at	

Signature

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Retirement Fund

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 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:

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 medical condition? (Please tick block)	Yes		No	
If yes, state position:				
Were any reasonable accommodations (changes/modification to work) offered to the employee?				
Reason, if any, why the work place 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?

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

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APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

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

WORK ENVIRONMENT:

Environment (Please tick block)	Hours Per Day	Environment (Please tick block)	Hours Per Day	Environment (Please tick block)	Hours Per Day
Office		Plant		Underground (Developing)	
Laboratory		Workshop		Underground (Stopes)	
Other		Production		Underground (Shaft)	

IDENTIFY THE PHYSICAL ACTIVITIES THE EMPLOYEE PERFORMED DURING A TYPICAL WORK DAY (Please indicate extent)

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

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 encdurance

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 give full details:

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:

Was the accident reported? (Please tick appropriate block) Yes No

If yes, please supply claim number:

If no, please specify details why not:

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Retirement Fund

APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

DETAILS OF DISABILITY (CONTINUED)				
Do you expect the employee to resume his/her normal occupation? (Please tick block)	Yes		No	
If no, will your company continue to employ him/her? (Please tick block)	Yes		No	
If yes, in what capacity?				
Do you expect the employee to be able to follow any other occupation? (Please tick block)	Yes		No	
If yes, please specify such occupations:				

TERMINATION OF EMPLOYMENT	
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):	

Date from (YYYYMMDD)	Date to (YYYYMMDD)	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		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		
YYYYMMDD	YYYYMMDD		

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Retirement Fund

APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

ABSENTEEISM RECORD (CONTINUED)

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

DECLARATION BY EMPLOYER:

Name of employer:	

Details of contact person at employer:

Title	Initials	Surname

Designation:	

Tel No.	Code		Number	
Fax No.	Code		Number	
Alternative No.	Code		Number	
E-Mail				

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 (YYYYMMDD)
Y Y Y Y M M D D

SENTINEL
Retirement Fund

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:		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? (Please tick block)	Yes		No		
If yes, please provide full details:					

DETAILS OF OCCUPATIONAL HEALTH MEDICAL PRACTITIONER:

Title	Initials	Surname

Qualifications:																										
Tel No. (Work)	Code									Number																
Fax No.	Code									Number																
Cell No.										Number																
E-Mail																										

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			Day of		2	0			at	

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 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 4.5kg 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).

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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

Identity Number	Passport Number

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?

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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 with regards to daily living?	

APPLICATION FOR PERMANENT DISABILITY (CONTINUED)

DECLARATION BY DOCTOR:															
Title		Initials					Surname								
Qualifications:															
Tel No.	Code						Number								
Fax No.	Code						Number								
Cell No.							Number								
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

SENTINEL
Retirement Fund

APPLICATION FOR RETIREMENT BENEFIT

Industry Number	

Title	Initials	Surname

Full Names (First Two Names in Full)	
1	2

Identity / Passport Number	

Tax Number	Gender (Please tick block)				Date Of Birth (YYYYMMDD)							
	Male		Female		Y	Y	Y	Y	M	M	D	D

POSTAL ADDRESS

P O Box Number	Suburb, City or Town	Postal Code

RESIDENTIAL ADDRESS

Street Number	Street Name

Suburb, City or Town	Postal Code

CONTACT DETAILS

Home Tel No	Code		Number
Cell No	Code		Number
E-Mail			

PLEASE INDICATE THE PREFERRED METHOD OF COMMUNICATION BY THE FUND BY TICKING THE APPLICABLE BLOCK

SMS		E-MAIL		TELEPHONIC		POSTAL	

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APPLICATION FOR RETIREMENT BENEFIT (CONTINUED)

Industry Number

MARITAL STATUS

Have you been divorced before? Yes No

Are you aware of a divorce order in respect of an allocation of a portion of your Sentinel pension interest to your ex-spouse? Yes No

If yes, has this amount been paid to your ex-spouse? Yes No N/A

Married | Married But Separated | Single | Widowed | Cohabiting Partner

DETAILS OF SPOUSE/PARTNER

Title | Initials | Surname

Identity / Passport Number

Gender (Please tick block) Male Female

Date Of Birth (YYYYMMDD) Y Y Y Y M M D D

Do you want to select a Flex Pension Option (If Applicable). Yes No

SECTION 1 : LUMPSUM OPTION

Maximum 1/3 Lumpsum | No Lumpsum

Selected Lumpsum Amount R .

SECTION 2 : MONTHLY PENSION

(A) PENSION OPTIONS FOR MEMBERS WITH A SPOUSE

PLEASE INDICATE YOUR SELECTION BY MARKING ONE OF THE FOLLOWING (Tick Applicable Block)

Term Certain Guarantee | 5 Years | 10 Years | 15 Years | 20 Years | 25 Years

75% Spouse pension after completion of term certain guarantee period

OR

100% Spouse pension after completion of term certain guarantee period

(B) PENSION OPTIONS FOR MEMBERS WITH NO SPOUSE

ONLY TO BE COMPLETED BY SINGLE, DIVORCED OR WIDOWED MEMBERS WHERE NO PROVISION IS TO BE MADE FOR A SPOUSE PENSION.

Term Certain Guarantee | 5 Years | 10 Years | 15 Years | 20 Years | 25 Years

SENTINEL
Retirement Fund

APPLICATION FOR RETIREMENT BENEFIT (CONTINUED)

Industry Number (Member)								

BANK DETAILS OF MEMBER

(All alterations must be signed by applicant and bank official)

THIRD PARTY, CREDIT CARD, POST OFFICE AND BOND ACCOUNTS ARE UNACCEPTABLE

To be verified by Bank Official as correct and active and belonging to the Applicant.

Surname				
Initials				
ID/Passport Number				
Name of Bank				
Branch Name				
Branch Code				
Account number				
Type of account	Savings		Cheque	
Date opened (YYYYMMDD)	Y Y Y Y M M D D			

Signature of Account Holder	Initials and Surname of Bank Official
	Signature of Bank Official
	OFFICIAL STAMP OF BANK

Date (YYYYMMDD)

Y Y Y Y M M D D

IMPORTANT : DOCUMENTARY REQUIREMENTS CHECKLIST

1	Copies of your and your spouse's Identity Documents or Passports (only if no identity document exists).	
2	Copy of marriage certificate (if applicable).	
3	Proof of termination of Employment.	
4	Relevant Divorce Order and Divorce Agreement (if applicable).	

APPLICATION FOR RETIREMENT BENEFIT (CONTINUED)

Industry Number								

ACKNOWLEDGMENT : OPTION TO ELECT DISABILITY RETIREMENT BENEFIT

I hereby confirm as follows:

1. I have completed the Fund's application for a disability retirement benefit.
2. I understand that:
   - a. If I leave service on or after my NRA, **or** claim a benefit after my NRA, I shall no longer have the option in terms of the Fund's Rules to:
     - i) Claim an in-service disability retirement benefit; or
     - ii) Claim a withdrawal benefit; or
     - iii) Transfer my benefit or fund credit to another fund
   - b. If I leave service on or after my NRA, **or** claim a benefit after my NRA, my only option will be to claim a retirement benefit / disability retirement benefit from the Fund, subject to the terms, conditions, restrictions and options provided for in the Rules;
   - c. In terms of the Fund's Rules read with current legislation and income tax practice, a maximum of one-third of the capital value of my benefit may be commuted for a lump sum. The balance is payable as a monthly pension. This is subject to certain exceptions which may or may not apply to me;
   - d. I may elect to commute less than one-third of the benefit, or even to not commute at all (i.e. to take the entire benefit as a monthly pension);
   - e. The Fund's Rules also provide other options relating to my benefit which have been explained to me;
   - f. The available options are subject to the Rules;
   - g. The Rules do not currently provide for a retiring or retired member to purchase an annuity from a third party with his/her retirement benefit or part thereof;
   - h. It is incumbent on me:
     - i. To ensure that I understand the options available to me and their consequences;
     - ii. To elect options best suited to my needs and if necessary, to obtain advice from a financial adviser or intermediary;
     - iii. To ensure that in completing the form, I elect the options that I intend to elect;
   - i. The Fund is entitled to assume that I understand my options and to give effect thereto;
   - j. Once the Fund gives effect to my options, I cannot revoke or change them. This includes:
     - i. My choice to take a disability retirement benefit (if I am eligible for another benefit);
     - ii. An election to commute less than one-third of my benefit for a lump sum, or to not commute at all (i.e. to take the entire benefit as a monthly pension);
     - iii. Any other options elected, subject to eligibility (including term certain guarantee, spouse's pension, second and third tier options, etc.);
3. I also acknowledge that by signing this document:
   - a. I waive any right to claim that I was not informed of the consequences of my elections;
   - b. I will have no basis to dispute the validity of my elections through the courts, the Pension Funds Adjudicator or any other forum, or to seek an order that the Fund must change any option/s that I elected;
   - c. I understand that my reasons for electing these options or any subsequent change in my financial or personal circumstances do not affect what is stated here.
4. I understand this document and sign it voluntarily and without duress.

Signature

Date (YYYYMMDD)							
Y	Y	Y	Y	M	M	D	D

SENTINEL
Retirement Fund

APPLICATION FOR RETIREMENT BENEFIT (CONTINUED)

NOTES ON COMPLETING THE NOMINATION FORM

Please note the following important information before completing your nomination form:

1. This nomination only applies to lump sum death benefits payable in terms of the Rules of the Fund. Death benefits are awarded and paid in terms of sect.37C of the Pension Fund Act to dependants, nominees or your Estate.

2. The Pension Funds Act defines a "dependant" as:
   - 2.1. A person to whom the pensioner is legally liable for maintenance; or
   - 2.2. A person who is in fact, in the opinion of the Trustees, dependent on the pensioner for maintenance; or
   - 2.3. The spouse of the pensioner and living together relationships of a permanent nature.
   - 2.4. Biological/legally adopted children of the pensioner including major children; or
   - 2.5. A person to whom the pensioner would have been legally liable for maintenance had he/she not died.

3. It is vital that the Trustees are informed of all persons who fall in the category of "Dependants". If they do not have this information there could be a considerable delay in determing and validating dependants before benefits can be paid.

   You must list all 'dependants' in this in this nomination form irrespective of whether they are dependent on you or not. Should you not wish for them to receive in a portion of the benefit simply write 000 % next to such person(s) name(s) and provide motivation to support your wishes.

4. You may also nominate people or organisations to receive a portion of or the entire benefit payable on your death. They are known as 'nominees'. A nominee is a person who is not a dependant on you and whom you wish to share in the benefit.

5. If you feel that the benefit should be managed or protected on behalf of a beneficiary who is incapable of taking care of his/her own affairs, a beneficiary fund can be created to protect his/her share of the benefit.

6. If you are not survived by dependants and your Estate is insolvent, the Fund will bring your Estate to solvency before making any payment to the nominees, in such instances payment to nominees.

7. Current tax legislation will be applied to and benefits may be subjected to tax, in the hands of the deceased pensioner who provided for a death benefit lump sum.

8. The nomination is made, acknowledging that:
   - 8.1. It is not binding on the Fund;
   - 8.2. It may be changed at any time by the pensioner who provided for the benefit;
   - 8.3. If any dependant or nominee should predecease you, their estate or heirs will not be entitled to claim a benefit, or portion thereof.

9. **PLEASE COMPLETE THIS FORM AND ENSURE THAT THE % OF BENEFIT COLUMN ADDS UP TO 100%.** If required additional pages may be added to the nomination, but must be dated and signed.

SENTINEL
Retirement Fund

PENSIONER NOMINATION FORM (CONTINUED)

1. DEPENDANTS & NOMINEES

Industry Number

	Initials and Surname	Date of Birth (YYYYMMDD)	Relationship to Pensioner	Telephone Number	Is this Person Dependant on you?	% of Benefit	Beneficiary Fund Required
1.		Y			Yes No	%	Yes No
2.		Y			Yes No	%	Yes No
3.		Y			Yes No	%	Yes No
4.		Y			Yes No	%	Yes No
5.		Y			Yes No	%	Yes No
6.		Y			Yes No	%	Yes No
7.		Y			Yes No	%	Yes No
8.		Y			Yes No	%	Yes No

2. DETAILS OF ALTERNATIVE BENEFICIARIES

In the event that the abovementioned person(s) pre-decease you please provide alternative persons/institutions that must be considered to share in your death benefit.

	Initials and Surname	Date of Birth (YYYYMMDD)	Relationship to Pensioner	Telephone Number	Is this Person Dependant on you?	% of Benefit	Beneficiary Fund Required
1.		Y			Yes No	%	Yes No
2.		Y			Yes No	%	Yes No
3.		Y			Yes No	%	Yes No
4.		Y			Yes No	%	Yes No

Signature of Pensioner

Date (YYYYMMDD)

Y Y Y Y M M D D

SENTINEL
Retirement Fund

APPLICATION FOR RETIREMENT BENEFIT (CONTINUED)

PENSIONER NOMINATION FORM (CONTINUED)

Industry Number (Pensioner)

Comments/Motivation (Continued): Please add additional page, ensure it is dated and signed.

I request that the Trustees pay the amount which may become payable from the Fund as a result of my death, to the persons mentioned above subject to the provisions of the rules of the Fund and the provisions of Section 37C of the Pension Funds Act. I also realise that in certain circumstances the Trustees of the Fund will have the descretion to ignore my request for the sake of equity and reasonableness in the disposal of such benefit. This nomination revokes and replaces all previous nominations made by me.

Nominations should be reviewed regularly!

Signature of Pensioner

Date (YYYYMMDD)
Y	Y	Y	Y	M	M	D	D

Please send your application form and required documents to :
Sentinel Retirement Fund,
Post : P O Box 61172, Marshalltown, 2107, Fax : (011) 481-8111, E-mail : info@sentinel.za.com