Claim

Policy number

partners life

Monthly Benefit Employer Questionnaire

1.0 Life assured

Title | First name(s) | Surname

2.0 Please answer the following

a) How long has the life assured been employed by you?

b) What was their gross monthly income immediately prior to ceasing work due to their disability? This amount includes motor vehicle allowances and fringe benefits.

c) What, if any, was the average monthly amount of overtime earned over the previous 12 months immediately prior to ceasing work due to their disability?

d) What were their main pre-disability duties? Please provide a copy of their role description if available.

Duty	Hours	Percentage %

e) How many days off work had the life assured taken due to illness or injury in the six months immediately prior to ceasing work due to their disability?

f) If possible would you be willing to allow the life assured to work for reduced hours or restricted duties? Yes ☐ No ☐

g) How long will the life assured continue to receive income from you including any sick leave payments following their disablement?

h) Do you provide your employees with any type of disability benefit other than sick leave? Yes ☐ No ☐
If **yes**, please give details.

3.0 Declaration and consent

I certify that the information provided is true and correct and that I am authorised to provide this information on behalf of the employer.

Name of person who completed this questionnaire

Position within the company

Contact phone number

Email

Signature

Date