

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



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 decree 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. _____

Email address: _____

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.

02

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 _____

DDMMYYYY

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 _____

DDMMYYYY

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 _____

DDMMYYYY

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.

03

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.

04

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 _____

SIGNATURE

COMPANY STAMP

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.

07

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

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.

INITIALS AND SURNAME OF WITNESS

"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."

Contact Details of Witness

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.

08

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: _____

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 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 _____

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 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, noise, 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.

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 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

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

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 _____
