



ANNEXURE F

SHORTEND APPLICATION FORM FOR ILL-HEALTH RETIREMENT

IMPORTANT

- 1 This form comprises of two parts, i.e. Parts A to B. The employer must complete Part A. The employee completes Part B
- 2 Please ensure that this form is duly completed, signed and accompanied of all the required supporting documents, since lacking information will delay finalisation of the application.
- 3 This application must only be used in the event where the Head of Department, following a full assessment of an employee for purposes of long temporary incapacity leave, decides that such an employee should be retired on grounds of ill-health in terms of the *Management Policy and Procedure on Incapacity Leave and Ill-health Retirement for Public Service Employees*.
- 4 This application form and supporting documentation is classified in terms of the Minimum Information Security Standards as 'Confidential'.



PART A: STATEMENT BY EMPLOYER

1. PARTICULARS OF THE EMPLOYEE TO BE CONSIDERED FOR ILL-HEALTH RETIREMENT																	
Surname							First names										
Date of birth	y	y	y	y	m	m	d	d	ID Number								
PERSAL number									Gender	Female	Please tick	Male	Please tick				
Date appointed in the Department	y	y	y	y	m	m	d	d	Date joined GEPF	y	y	y	y	m	m	d	d
Annual pensionable salary							Retirement age										
Address																	
Contact Numbers	@ home				@ work				Cell phone								
	Code & tel number				Code & tel number												

2. CONTACT DETAILS OF DEPARTMENT (Please provide details of two contact persons)			
Physical address of Department			
CONTACT PERSON IN DEPARTMENT		Designation	
Tel no	Code & tel. Number	Fax no	Code & fax number
E-mail address			
ALTERNATIVE CONTACT PERSON			
Contact person in department		Designation	
Tel no	Code & tel. Number	Fax no	Code & fax number
E-mail address			



3. DETAILS OF EMPLOYMENT						
Job title						
Current work status				Still working	YES	NO
				Full-time/Part-time		
On normal sick leave	YES	NO	N/A	Last day at work		
On incapacity leave	YES	NO	N/A			

4. ATTACHMENTS (COMPULSORY)	TICK
▪ Copy of Report to the Health Risk Manager (attachments included)	Please tick
▪ Recommendation from Health Risk Manager	Please tick
▪ A certified copy of the employee's identity document	Please tick

DECLARATION	<p><i>I hereby declare that the employee has been informed of the conditions of the Fund rules concerning ill-health benefits.</i></p> <p><i>I hereby declare and warrant that the information given is factual, true and correct, and that no material information has been neither withheld nor any relevant circumstances omitted.</i></p>											
Signature of Head of Department or delegate				Date	y	y	y	y	m	m	d	d
Print Name				Designation								



PART B: STATEMENT BY EMPLOYEE

PERSONAL PARTICULARS																					
Surname																					
First names																					
Date of birth	y	y	y	y	m	m	d	d	ID No.												
PERSAL number																					
Residential address							Postal address														
Telephone numbers:																					
@ work				Code & tel. number				@ home				Code & tel. number									
Alternative contact number								Cell No													

DECLARATION	<i>I hereby declare and confirm that the answers given by me or the information disclosed in this form are complete in all respects, are both true and correct (whether in my handwriting or not) and that no material information has been withheld nor has any relevant information regarding my physical and/or mental health been omitted, either intentionally or negligently.</i>		
Signature of employee or of the person completing form if applicant is unable to do so.		Date	

Signature of witness _____ Date _____