



ANNEXURE F

SHORTEND APPLICATION FORM FOR ILL-HEALTH RETIREMENT

IMPORTANT

- 1 This form comprises two parts, i.e. Parts A and B. The employer must complete Part A. The employee must complete Part B
- 2 Please ensure that this form is duly completed, signed and accompanied by all the required supporting documents, as missing or omitted 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 the grounds of ill-health in terms of the *Policy and Procedure on Incapacity Leave and Ill-health Retirement (PILIR)*.
- 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						ID No.						
PERSAL number						Gender	Female		Male			
Date appointed in the Department						Date joined GEPF						
Annual pensionable salary						Retirement age						
Address						E-mail address:						
Contact Telephone Numbers	@ home			@ work			Cell phone					

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



3. DETAILS OF EMPLOYMENT				
Job title				
Current work status		Still working	Yes	No
Please mark below with a tick in the applicable box			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)	Please Tick
▪ Copy of Report to the Health Risk Manager (attachments included)	
▪ Recommendation from the Health Risk Manager	
▪ A certified copy of the employee's identity document	

DECLARATION	<i>I hereby declare that the employee has been informed of the conditions of the Fund rules concerning ill-health benefits.</i>		
	<i>I hereby declare and warrant that the information given is factual, true and correct, and that no material information has been withheld or any relevant circumstances omitted.</i>		
Signature of Head of Department or delegate		Date	
Print Name		Designation	



PART B: STATEMENT BY EMPLOYEE

PERSONAL PARTICULARS				
Surname				
First names				
Date of birth				ID No.
PERSAL number				
Residential address			Postal address	
Telephone numbers:	@ work (Code and No)		@ home (Code & No)	
Alternative contact number			Cell No	
E-mail address:				

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 1		Date	
Full Name & Surname :			
Tel No. :		Code	
Cell No. :			

Signature of witness 2		Date	
Full Name & Surname:			
Tel No. :		Code	
Cell No. :			