ANNEXURE F

SHORTEND APPLICATON FORM FOR ILL-HEALTH RETIREMENT

IMPORTANT

1. This form comprises two parts, i.e. Parts A to 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 *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		ID No.		
PERSAL number		Gender	Female	Male
Date appointed in the Department		Date joined GEPF		
Annual pensionable salary		Retirement age		
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			

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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 hereby declare that the employee has been informed of the conditions of the Fund rules concerning ill-health benefits.*** ***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.***		
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	

DECLARATION	*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.*		
Signature of employee or of the person completing form if applicant is unable to do so.		Date	

Signature of witness ____________________ **Date** ________________