



military veterans

Department:
Military Veterans

REPUBLIC OF SOUTH AFRICA

**BENEFIT ACCESS
FORM:
COMPENSATION**

*MILITARY
VETERANS ACT,
SECTION 5.*



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FORCE NUMBER/ SERIAL NUMBER

<p>SHOULD YOU REQUIRE ASSISTANCE COMPLETING THIS FORM PLEASE CONTACT: HELPLINE: 080 232 3244</p> <p>INSTRUCTIONS</p> <ul style="list-style-type: none"> You are applying for compensation for injury, trauma and disease benefit in terms of the Military Veterans Act 18 of 2011 This benefit is for Military Veterans who sustained disabling injuries or severe psychological and neuro-psychiatric trauma or who suffers from terminal illness resulting from the military veteran's participation in military activities (Military Veterans Regulations No. R. 122) You should ONLY 	PERSONAL DETAILS (TO BE COMPLETED BY APPLICANT)															
	Surname															
	Full Names								Initials							
	Identity Number												Gender		M	F
	Date of Birth										Cell No.					
	Residential Address															
			Postal Code													
	Email Address								Tel No							
	Marital Status		Married			Widowed			Never Married				Divorced			
	<i>If Married, please provide the following details of your spouse</i>															
	Surname								Initials							
	CELL NUMBER															
	Dependents (<i>in relation to a military veteran, means any person who is legally or factually dependent on that military veteran for support and maintenance</i>)															
	Surname				Initials		Identity Number									



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A military veteran convicted of rape, murder, robbery, theft or high treason committed after 27 April 1994 and sentenced to imprisonment for a period exceeding 5 years without option of a fine is disqualified from receiving any benefits in terms of the Act.

A Military Veteran Military Veterans who sustained disabling injuries or severe psychological and neuro-psychiatric trauma or who suffers from terminal illness resulting from the military veteran's participation in military activities may apply for a lump sum payment as a compensation if: the disabling injury; the severe

QUALIFICATION CRITERIA FOR COMPENSATION BENEFIT TO BE COMPLETED BY THE VETERAN

DO YOU HAVE A CONVICTION FOR A CRIME COMMITTED AFTER 27 APRIL 1994?		YES	NO
IF YOU ANSWERED YES IN QUESTIONS	What were you convicted of?		
	Imprisonment Period	Fine	R
Have you ever applied for Military Pension or Compensation Benefit?	If Yes, what is your MP number		
Do you have any other income?	If "YES", give details (From where, for what, how much)		

DETAILS OF MILITARY SERVICE AND INJURY/Traum OR DISEASE :TO BE COMPLETED BY THE VETERAN

Former Force	Date of Service	Place of Service	Country

EXPLAIN THE NATURE AND HISTORY OF MILITARY-RELATED DISABILITY (IES) OR DESEASE. *If you require additional space, please use a separate sheet and attach it to this access form.*



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psychological and neuro-psychiatric trauma; or terminal disease resulted from military activities and the effect of such disability, trauma or disease is an ongoing event. The Medical assessment shall confirm the link between the injury, trauma or disease and his/her participation in military activity. The military veteran should not have accessed or received similar benefit in terms of any other legislation. NB: **Amount payable** are determined in accordance with Military Pensions Act 84 of 1976, annual gazette issued by the Minister of Finance.

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PROVIDE THE NAMES OF PEOPLE WHO WITNESSED OR WHO HAVE KNOWLEDGE OF YOUR INJURY/TRAUMA/DISEASE

INITIAL AND SURNAME	CONTACT NUMBERS	RELATIONSHIP



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TO BE COMPLETED BY A MEDICAL PRACTITIONER

This form is completed for the Military Veteran who is applying for Compensation Benefit for trauma/disability/disease suffered while in Military Service in terms of the Military Veterans Act (Act no. 18 of 2011). In order to determine eligibility for Compensation, a medical report is required for evaluation/review by Medical Assessors appointed by the Department of Military Veterans. All information provided shall be treated with full confidentiality in line with South African Legislation.

PERSONAL DETAILS OF THE PATIENT													
SUNAME									INITIALS				
FULL NAMES													
IDENTITY NUMBER												GENDER	
PAST INJURIES, CAUSE, MEDICAL CONDITIONS, EXISTING CONDITIONS AND TREATMENT:													
ICD 10 CODES			MEDICAL HISTORY										
			<i>MEDICAL NOTES/REPORT TO BE ATTACHED AS AN ANNEXURE TO THIS APPLICATION FORM. (KINDLY MOTIVATE HOW THE CONDITION IS LINKED TO MILITARY PARTICIPATION OR ACTIVITY)</i>										
DATE OF FIRST CONSULTATION							DURATION OF THE CONDITION						



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DETAILS OF THE MEDICAL PRACTITIONER							
DOCTOR'S NAME AND QUALIFICATION							
PRACTICE NUMBER (HPCSA or BHF)		ADDRESS					
		CONTACT NUMBER					
I HEREBY DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE INFORMATION SET OUT ON THIS MEDICAL REPORT IS TRUE AND CORRECT IN EVERY RESPECT							
SIGNATURE		DATE					

DECLARATION AND CONSENT

I, the undersigned (*Full Names*)
.....

I consent to and authorise the Department of Military Veterans to contact any person or entity for purposes of obtaining or verifying such information or documentation related to my claim for compensation.

I am the applicant whose details appear in this application form. The content of the said benefit access form falls within my personal knowledge, unless stated otherwise, and are both true and correct.

APPLICANT'S SIGNATURE **IDENTITY NUMBER**

DOCUMENTS CHECKLIST

	Application form		
	Certified Identity Documents		
	Proof of Military Service		
	Medical Report in support of disability/injury		
	Two (2) Affidavits from people with knowledge of disability/injury		