ASISA
Association for
Savings & Investment
South Africa

ASISA GUIDELINE FOR THE MANAGEMENT OF DISABILITY CLAIMS ON PSYCHIATRIC GROUNDS

Date of first publication: **2017 (3rd edition)**

Date of last update: **31 March 2026**

1. HISTORY

1.1. The need for a standardised approach to the assessment of claimants with psychiatric disorders for medical disability was initially addressed in 1995 by a task-team comprising nominated psychiatrists from the South African Society of Psychiatrists and medical advisors of the life insurance industry.

1.2. With the advent of time, the resulting Second Edition was drawn up by the participants, distributed widely for comments, and approved by the executive committee of the South African Society of Psychiatrists.

1.3. It was felt by the life insurance industry, in light of significant developments in diagnosis, management and therefore outcomes for psychiatric patients, that the Second Edition required updating to include reference to new diagnostic tools and management techniques in order to be as fair as possible to all parties.

2. INTRODUCTION

2.1. Psychiatric causes of disability now comprise a large proportion of disability claims in the South African insurance industry. Among these, depression, mood disorders, anxiety and post-traumatic stress disorders are leading the diagnosis list. Work-related stress is often cited as a major contributing factor.

2.2. The assessment of disability on psychiatric grounds has become increasingly difficult, *inter alia* due to the following factors:

2.2.1. inconsistencies in diagnosis, management and prognosis between medical professionals;

2.2.2. a lack of objectivity in reports from treating psychiatrists;

2.2.3. claimants being informed by treating psychiatrists that they have a permanent condition before allowing sufficient time for the treatment plan to work;

2.2.4. inadequate treatment in terms of:

2.2.4.1. the lack of access to (affordable) treatment;

2.2.4.2. the insufficient duration of treatment;

2.2.4.3. the appropriateness of the treatment modalities applied (i.e. not following the evidence-based best treatment approach);

2.2.4.4. the lack of referrals to rehabilitation specialists (e.g. psychologists or occupational therapists);

2.2.4.5. the lack of vocational rehabilitation programs;

2.2.5. side effects of treatment which negatively impact the claimant's ability to function and work;

2.2.6. claimants who suffer from purely work-related or psychosocial stressors, may very well be able to function in a different occupational environment, in which event, the requirements for disability are not likely to be met;

2.2.7. extended time off work being afforded without adequate reason for doing so;

2.2.8. the fact that psychiatric conditions are largely self-reported and may involve symptom-exaggeration by claimants.

2.3. The need for a more consistent approach in assessing psychiatric disability claims was identified. ASISA Medical and Underwriting Standing Committee and a task team from the South African Society of Psychiatrists accordingly compiled this peer-reviewed guideline to aid the assessment and reporting on psychiatric disability.

3. PURPOSE OF THIS DOCUMENT

3.1. In the South African insurance industry, which includes both private insurance policies and employee benefit schemes, a large proportion of disability claims are due to psychiatric conditions. A need was identified by the industry for guidelines in assessing psychiatric disability claims in a consistent manner.

3.2. This **Guideline for the Management of Disability Claims on Psychiatric Grounds** ("**Guideline**") aims to provide guidelines to assist with the management of disability claims on psychiatric grounds, including to:

3.2.1. assist the understanding by the psychiatric community as to what is expected from a psychiatric assessment and report for insurance claim purposes and why the information is necessary;

3.2.2. improve consistency in psychiatric evaluations and reporting for purposes of a

disability assessment, for example by providing a list of recommended minimum information required for making an informed decision on disability;

3.2.3. provide for a consistent approach by insurers in assessing disability claims on psychiatric grounds;

3.2.4. explaining the difference between impairment and disability and impressing upon psychiatrists that their role is limited to the assessment of impairment (as opposed to disability), *inter alia* to prevent claimants being labelled as disabled prematurely;

3.2.5. promote the overarching objective of Treating Customers Fairly ("**TCF**"), namely to ensure that all clients are treated fairly throughout the product life cycle, including during claims processing;

3.2.6. raise awareness of the importance of re-entry of claimants into the workplace, even after a period of prolonged absence from work, with the aim to ensure that individuals with psychiatric disabilities can attain and maintain maximum independence and full participation in society on an equal basis with others.

3.3. This Guideline is being shared with ASISA members and the public at large for their consideration and voluntary implementation and is non-binding on ASISA members.

3.4. Please note that this Guideline contains references to source material that was available at the time of drafting this Guideline. It is the responsibility of Members to stay abreast and take cognisance of any amendments or additions to the source material from time to time.

4. ETHICAL AND FAIRNESS CONSIDERATIONS

Recommendations specific to insurers

4.1. The business of insurance carriers is to insure uncertainty, using evidence-based scientific measurement criteria. Insurers should always aim to pay all legitimate claims as speedily and expeditiously as possible.

4.2. Insurers are encouraged to apply the following basic ethical and fairness principles:

4.2.1. transparency;

4.2.2. equity;

4.2.3. fairness;

4.2.4. consistency;

4.2.5. objectivity.

4.3. First and foremost, insurers should pay heed to TCF and ensure that their customers, irrespective of their mental status, are treated fairly and, more specifically, that customers do not face unreasonable post-sale barriers imposed by firms to submit a claim.

4.4. TCF requires that vulnerable customers, including those with mental health conditions, such as depression and anxiety, are treated with due care and consideration. This could involve:

4.4.1. assessing potential vulnerability and providing appropriate support;

4.4.2. ensuring that insurers' culture supports the fair treatment of all customers during the claims process, including those with mental health conditions;

4.4.3. providing customers with a level of care that is appropriate given the characteristics of the customers themselves.

4.5. Claimants suffering from mental illness should be treated with the same respect and dignity as those with other medical conditions. These diagnoses carry the risks of morbidity and mortality, as does many serious medical conditions. Psychiatric conditions should not be treated differently from any other medical condition in terms of policy benefits design, underwriting practices, claims protocols and other insurance practices.

4.6. Confidentiality of the contents of psychiatric reports are of paramount importance and insurers should take every precaution to safeguard their confidentiality. In addition, the source/author of any psychiatric report should be protected as far as possible. Psychiatric reports should only be disclosed to third parties with the consent of the customer.

4.7. When second psychiatric opinions are sought, the customer should clearly be informed that this is not because his treating psychiatrist is not being regarded as an expert, but because it is, in practice, nearly impossible to divorce the two roles of therapist and objective adjudicator. Therefore, a second, independent opinion is required in conditions where the symptomatology and impairment are of a subjective nature. This practice is in accordance with international practice.

4.8. An insurer may be hesitant to make a lump sum disability payment for fear that the money may be mismanaged or because people with diminished mental capacity are particularly vulnerable when it comes to falling for scams. However, if the customer is entitled to payment (the claim

is approved), the claim must be paid out to prevent the insurer from breaching the policy contract. If a *curator bonis* or an administrator has been appointed to manage the customer's affairs, payment should be made to those persons. In cases where such persons have not been appointed, Members should ensure that internal processes are put in place for dealing with such cases lawfully. The insurer's obligations typically end upon payment of the claim. This means that it is not the responsibility of the insurer to ensure that the money is not mismanaged after payment. Having said that, there is a real risk that people receiving lump sum disability payouts become disillusioned by the limited buying power of such a payouts, especially when they suffer from psychiatric conditions. This may ultimately contribute to the worsening of their psychiatric condition through financial despair. It is recommended that such customers are informed by the insurer of the benefits of obtaining sound financial advice and planning from a qualified financial advisor.

4.9. The Policyholder Protection Rules set out what pre-contractual and ongoing disclosures must be made to policyholders, including in connection with the benefits, limitations and exclusions. This information should always be explained in clear and understandable terms. Transparency should be practised pro-actively, not reactively. In circumstances where an insurer can demonstrate that due to the nature of a group scheme, it is not reasonably practicable for the insurer to engage directly with the member in the normal course of business, the insurer should have arrangements in place with the policyholder concerned that facilitate and support the provision of the required information by the policyholder to the member.

4.10. In dealing with disability claims, clear communication with the claimant can solve many misperceptions and misunderstandings. Clear and precise reasons for declining or postponing claims should be given in plain and understandable language.

4.11. When it is found that sales intermediaries have misrepresented products at sales stages, appropriate remedial and punitive measures should be taken by the insurer involved.

Recommendations specifically to employers

4.12. The aim of workplace accommodation is to reduce the impact of an employee's impairment on the employee's functional capacity and to enable the employee to fulfil the essential physical and mental outputs of a specific job. For all practical purposes, an employee who has become disabled should be treated as someone with a disability. The employer's obligation is to 'reasonably accommodate' the employee by investigating *all* available options to keep the employee productive, whether in the same (but adapted) position, or a different position (albeit on new, agreed and possibly less beneficial terms for the employee) before even considering dismissal. Reasonable accommodations should also be instituted in a manner that will

empower the affected employee and that is non-stigmatising. Employers should take particular care before dismissing an employee for medical incapacity. Due regard must be had to the Code of Good Practice: Dismissal of the Labour Relations Act and the provisions relating to unfair discrimination under the Employment Equity Act.

4.13. Sick leave or temporary part-time work, should be made available where possible to encourage employees to follow recommended psychotherapy programmes, psychiatric rehabilitation protocols etc. This should ensure better outcomes of for customers and contribute to a higher rate of return to the workplace.

4.14. Employers should not encourage or counsel employees to claim "increased" benefits under a disability claim, as opposed to taking a dismissal package. This would not only be unethical and unfair towards the employee, but could leave employees disillusioned when a disability claim is unsuccessful.

4.15. In the workplace, health data (for example data relating to the mental health of the employee, is considered sensitive and personal information that must be protected from unauthorised access. Employers are required to ensure that such personal information is kept secure and only accessible to authorised personnel.

5. DEFINING IMPAIRMENT AND DISABILITY

It is vitally important in the context of insurance disability claims to distinguish between the concepts of impairment and disability, because impairment doesn't necessarily equate to disability. Factors like motivation, technology and accommodations can influence how impairment impacts an individual's life and work. Assessing disability accordingly requires a more comprehensive and functional approach than measuring impairment.

It is recommended that the following generally accepted definitions are applied:

Impairment

5.1. The World Health Organisation ("**WHO**") defines "*impairment*" as "*any loss or abnormality of psychological, physiological or anatomical structure or function.*"[1] In essence, this is a medical concept describing an alteration in an individual's health status. Impairment is assessed by medical means after a diagnosis has been made and appropriate treatment given.

[1] World Health Organisation. International Classification of Impairments, Disabilities, and Handicaps Geneva, Switzerland: World Health Organisation; 1980.

5.2. The American Medical Association ("**AMA**") Guides defines "*impairment*" as a "*significant deviation, loss, or loss of use of any body structure or function*".

5.3. For purposes of assessing impairment, it is important to have regard to those activities of daily living a person can perform and those which the person cannot perform.

5.4. It is also important to recognise that "normal" is not a fine point or absolute. The concept of "normal" in psychiatry is complex and multifaceted. It involves distinguishing between normal variations in behaviour and those that indicate a mental disorder. What is "normal" can also vary depending on age, gender and other factors. Interpretations of normal that are too strict can result in over- or underestimation of the degree of impairment.

5.5. In practical terms, therefore, an impairment assessment entails examining the diagnosis and current and future treatment options before determining on medical grounds which functions the person is still able to perform and which not. Occupational therapists are the well positioned to assess functional impairment in mentally ill claimants through functional capacity assessments and, hence, play an important role in determining the extent of impairment.

Disability

5.6. The WHO defines "*disability*" as "*any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.*"[2].

5.7. The AMA defines *"disability*" as "*an alteration in the individual's capacity to meet personal, social or occupational demands or statutory or regulatory requirements because of an impairment*".[3] It also defines "*disability*" as "*an umbrella term for activity limitations and participation restrictions*".

5.8. Assessing disability entails assessing the extent of the person's impairment in conjunction with their job description, policy disability terms and conditions, as well as personal factors, such as education and experience. To assess disability means determining the extent to which the person's impairment affects the ability to execute personal, social or occupational activities in the context of the definitions provided in the policy contract. In the context of disability insurance, activities most often relate to the occupational duties performed by the person prior to the impairment.

---

[2] World Health Organisation. International Classification of Impairments, Disabilities, and Handicaps Geneva, Switzerland: World Health Organisation; 1980.

[3] Guides to the Evaluation of Permanent Impairment, Fourth Edition. American Medical Association; 1995.

5.9. It follows that no medical practitioner is in a position to express an opinion on disability. The practitioner may be fully informed regarding the medical condition and its effects of the activities of daily living, but he/she usually does not have sufficient information to determine disability, e.g. information regarding:

5.9.1. the insured's working history, previous occupations, qualifications, experience etc;

5.9.2. the relevant job description; and

5.9.3. the policy terms and conditions (including definitions).

5.10. The doctor involved should therefore only supply the insurer or employer with detailed medical information and express an opinion on functional impairment due to the illness/disease and not on disability.

5.11. The examining doctor should inform the claimant that the decision on disability will be made by the insurer concerned through a panel of experts, after having considered input from the treating doctors, independent psychiatrists, psychologists, occupational therapists, insurer's legal advisors, claims assessors and other relevant persons. The treating doctor should also inform the claimant that the mere fact that he/she has booked the patient off from work due to impairment, does not mean that the disability claim will be approved.

5.12. The evidence from the treating psychiatrist is part of the assessment, but will not, in itself, be sufficient to make a decision regarding disability. It is important that an independent psychiatrist reviews the case and gives an objective opinion on the impairment and treatment.

5.13. The independent psychiatrist should be provided with the necessary consents and all other relevant documents and information relating to the claimant, as well as medical and psychiatric reports.

6. ROLES AND RESPONSIBILITIES

The treating psychiatrist

It is recommended as follows:

6.1. The role of the treating psychiatrist is to diagnose, treat and manage the claimant's condition and impairment. Although the treating psychiatrist should provide expert information on the medical condition in question and activities of daily living, it is also important that the treating psychiatrist reports on the following:

6.1.1. To the extent that the treating psychologist has such information, details of the claimant's job description, working history, previous occupations, qualifications, and experience;

6.1.2. detailed medical information related to the claimant's clinical condition and the history thereof;

6.1.3. current or recent occupational functioning and activities of daily living, based on the input from an occupational therapist after a formal functional capacity assessment has been done.

6.1.4. functional impairment and not on perceived disability. This is particularly important where long-term sick leave is being granted. This recommendation aims to achieve the following goals:

6.1.4.1. the therapeutic relationship is not jeopardised through the involvement of the treating psychiatrist in the disability decision-making process;

6.1.4.2. the pressure is taken off the treating doctor by moving the disability decision-making to the insurer;

6.1.4.3. the claimant will not be assumed to be disabled or unable to return to work prematurely.

6.2. The onus is not on the treating psychiatrist to interpret the details of the insurance contract. Where the claimant is unsure about his/her insurance contract, the claimant should be advised to obtain full details from the insurer or an accredited financial advisor.

The independent psychiatrist

6.3. It is recommended as follows:

6.3.1. Independent psychiatrists should have an interest in disability claim work and assessment of psychiatric impairment and must be able to provide sufficiently detailed independent reports for an insurer to assist them in making appropriate decisions regarding psychiatric disability. They should be familiar with related insurance terminology and requirements for accurate reporting. They should have no affiliations with the relevant insurer that could lead to conflicts of interest and should be able to provide objective external opinions.

6.3.2. The independent psychiatrist should follow the guidelines as set out for the primary

treating psychiatrist in compiling a full clinical report. It may also be necessary for the independent psychiatrist to liaise with the treating psychiatrist to obtain additional information if required..

6.3.3. Importantly, just as with the treating psychiatrist, the independent psychiatrist may not express an opinion regarding disability, only regarding impairment.

6.3.4. There may also be a need for discussion with the medical advisor of the insurer. At all times there should be an open line for discussion between the medical advisors and the independent psychiatrists and, in some of the more difficult cases, a third opinion from a further psychiatrist may even be sought.

6.4. The independent psychiatrist may have a different opinion with regards to a diagnosis or prognosis than the treating psychiatrist. Claims assessments should be conducted from a holistic point of view and have regard to the opinions of both the treating and independent psychiatrist.

The occupational therapist and psychologist

6.5. Occupational therapists and psychologists are also of great value in assisting to make a final decision on disability.

6.6. Occupational therapists can play a vital role in disability assessments by evaluating functional abilities, developing personalised treatment plans and facilitating independence in daily activities.

6.7. Psychologists can also play a vital role in assessing psychiatric disabilities by conducing systematic evaluations that help understand an individual's psychological functioning and emotional well-being.

6.8. It must be emphasized that no one party's input is of greater value than another and all the information received should be evaluated in context.

Importance of not prematurely labelling a claimant as disabled

6.9. From an insurance perspective, all treatment options and avenues should have been pursued before someone is classified as disabled. It could be very harmful to a customer if he/she is prematurely labelled as disabled, including for the following reasons:

6.9.1. It may result in a mind-set that may be to the detriment of the future well-being of the claimant, their identity and self-worth and can limit a patient's sense of agency over

their mental health journey. Self-stigma can significantly hinder recovery and attempts at rehabilitation or to return to work.

6.9.2. Often the label “psychiatric disability” leads to harmful stereotyping and stigmatising, as it is viewed as shameful, something to be pitied or that something is “wrong” with a person. This can have profound effects on the claimant.

6.9.3. Premature labelling may lead to altered family and social relationships and altered vocational adjustment.

6.9.4. Claimants should be given the opportunity to be rehabilitated back into gainful employment before the label of disability is applied. The outcome of psychiatric treatment has been proven to be better where a claimant has the view that return to work is the expected outcome.

6.9.5. A person prematurely labelled as disabled may disclose this perceived status when applying for additional insurance cover and may, as a result, be unable to obtain further disability cover or life insurance.

6.9.6. A person who has been labelled as “disabled” may find it difficult to gain future employment.

6.9.7. People who are prematurely labelled as disabled on psychiatric grounds may succumb to poor lifestyle habits such as increased smoking, poor eating habits and consequent weight gain.

The insurer

6.10. The insurer’s role of assessing disability on psychiatric grounds involves a comprehensive evaluation of medical evidence, considering the full context of the claimant’s condition and job demands. It is recommended that:

6.10.1. Insurers ensure that they accurately interpret policy definitions and terms and that claims are treated fairly and objectively. It is crucial for insurers to maintain confidentiality of medical reports and to ensure that the final decision on disability is made by (a panel of) appropriately qualified individuals.

6.10.2. Insurers set out and communicate the relevant terms and conditions of the policy document, the requirements for claims assessments and other parameters in a clear and understandable manner.

6.10.3. The policy contract at least includes the following:

6.10.3.1. the fact that claims will only be paid if the customer is diagnosed with a medical condition covered under the policy contract;

6.10.3.2. any deferred or waiting period, i.e. the period that has to elapse during which the insured is continuously unable to perform his/her duties before a claim will be considered);

6.10.3.3. a description of the definition of occupational disability (asthis may differ between insurers);

6.10.3.4. any applicable benefit limitations and/or exclusions. These may be applied individually at underwriting stage or as standard exclusion limitations/exclusions. The policyholder should also be made aware of these benefit limitations or exclusions before they enter into the policy contract.

6.11. It is important for claimants to be aware that being declared medically boarded or medically incapacitated to continue working by an employer or even being classified as permanently disabled by one insurance company does not imply that all the claimant's disability policies will be paid out. This is due to the differing terms of the contracts between the insurers and claimants.

The claimant

6.12. The role of the claimant in psychiatric disability claims involves several key responsibilities:

6.12.1. In all instances, the onus is firstly on the customer to prove their claim for disability to the insurer. Sufficient evidence should be provided by the customer for the insurer to make a fair assessment.

6.12.2. The claimant must present a comprehensive medical report that accurately reflects the psychiatric condition and its impact on the claimant's ability to perform his/her job. This includes documentation of diagnosis, treatment history and any relevant medical tests or assessments.

6.12.3. The claimant must demonstrate that the psychiatric condition has impaired their ability to perform their job effectively. This may involve providing evidence of the job's cognitive demands the specific tasks required and how the psychiatric condition

affects the claimant's performance.

6.12.4. The claimant should actively participate in any recommended rehabilitation and treatment programs as far as reasonably possible. This may include therapy, medication management and vocational rehabilitation to improve their condition and prepare them for return to work. Claimants who do not follow recommended treatment and rehabilitation programs are at risk that their claim will not be approved.

6.12.5. The claimant should be aware of the claims process, including the timeline for submission, the types of evidence required and the potential outcomes of the claim. They should also be prepared to respond to any inquiries from the insurer and to provide updates on their condition and progress.

6.12.6. It is important that the claimant checks the occupation/s covered by the contract before they claim to ensure they are eligible to claim for that condition. If in doubt, their financial advisor or insurer would be able to assist.

6.12.7. It is important for customers to be aware that their dismissal by their employer for medical reasons or being classified as permanently disabled by one insurance company does not imply that all the claimant's disability policies will be paid out. This is due to the differing terms of the contracts between the insurers and the customer.

7. ASSESSING DISABILITY

It is recommended as follows in respect of the assessment of disability claims on psychiatric grounds:

7.1. Guidelines and criteria for disability assessment should be evidence-based.

7.2. Claims assessments should be done fairly, objectively and consistently.

7.3. Each individual claim should be assessed on its own merits and not with a broad-brush approach.

7.4. Disability claims on psychiatric grounds should only be considered following diagnosis and adequate treatment by a psychiatrist.

7.5. Insurers should accurately interpret policy definitions and consider the full context of an individual's condition and job demands. It is important that sufficient weight is given to all the available evidence.

7.6. A disability claim should be assessed by evaluating at least the following four criteria:

7.6.1. specific claimant particulars;

7.6.2. job description and occupational duties performed by the claimant prior to the onset of the impairment;

7.6.3. the disability terms and conditions contained in the policy contract;

7.6.4. the medical condition and reasonable medical treatment.

Claimant particulars

7.7. Factors that may be considered include:

7.7.1. age;

7.7.2. experience, level of education and qualifications;

7.7.3. previous earnings / income;

7.7.4. previous occupations.

Job description

Where relevant, the occupation for which the claimant is covered by insurance is typically specified in the contract. Cover may be for specific or non-specific occupations (see paragraph 7.8 below).

Disability categories

7.8. Definitions of disability will differ from insurer to insurer, but, generally, the following types of disability cover are offered:

According to type of work

7.8.1. Own occupation

A disability claim under "own occupation" typically covers individual who are unable to perform their specific current occupation due to a medical condition. This is generally a more expensive type of disability cover and is usually aimed at professionals or people with specific types of occupations. In these cases, the exact occupational description should be evaluated in terms of the medical impairment.

7.8.2. Own / similar occupation

A disability claim under “own/similar occupation” typically covers individual who are unfit to follow their own specific occupation or similar occupation (an occupation that closely resembles their own specific occupation) or an alternative occupation which they may reasonably be expected to be able to follow, taking into account their ability, education, training and experience. In practice these are the claims which most often lead to misunderstanding and unhappiness. Claimants may be found unfit for their specific or similar occupation, but the insurer may decline the claim in terms of the policy contract if the claimant could still reasonably be expected to follow an alternative occupation.

7.8.3. Any occupation

This is generally an inexpensive type of disability cover with very wide policy cover. However, in this case, the degree of disability generally has to be very high for a claim to succeed. Here factors such as qualifications, experience and income are irrelevant and the claimant literally has to be unable to do any type of work, e.g. even being unable to perform simple tasks like access control to buildings / venues or selling tickets.

According to type of disability

7.8.4. Total and permanent disability

Here the impairment has to be optimally treated and still have resultant impairment to such a degree that the person is totally and permanently unfit to work. It also means that the impairment should be irreversible. Impairments which are treatable and episodic in nature should therefore not qualify as causes for disability in this category. The claimant should have reached a stage of maximal medical improvement of their condition, having allowed sufficient time on an accepted treatment protocol to allow for this. Maximal medical improvement is generally reached when no further improvement is expected over the next 12 months.

7.8.5. Temporary disability

In this category, a monthly income is provided temporarily and periodic medical review is required to determine sustained disability. Temporary disability due to treatable or episodic disorders (e.g. a depressive episode) may qualify for a claim, provided the other parameters of disability assessment are met.

Work stress

It is recommended as follows:

7.9. Work stress, as an adverse reaction to excessive pressures or demands, should not be classified as a disability in itself.

7.10. Although managing a condition may be hindered by work stress, work stress, as an adverse reaction to excessive pressures or demands, should not be classified as a disability in itself. However, if it leads to a condition that substantially limits one or more major life activities, it may be considered a disability. The key factor in determining whether stress-related conditions qualify as disabilities accordingly lies in their impact on an individual's ability to perform major life activities and their job. Should a claimant present with work stress as the major reason for the claim, alternative work opportunities, work grading, work rehabilitation, stress management and treatment measures should be considered before classifying someone as disabled on psychiatric grounds. Should this be a precipitating factor contributing to a psychiatric diagnosis, then a counsellor or psychologist can play an important role to plan to assist the claimant to manage either the stress or the work situation.

Unavailability of employment

7.11. The fact that an employer has terminated the claimant's employment due to medical reasons and the unavailability of alternative employment within the claimant's existing employer or with another employer should not be a factor in assessing disability. The onus is on the claimant to find alternative employment. Accordingly, with respect to disability assessment, the lack of availability of another job within the employer or in the open labour market should be irrelevant. The policy contract should insure the ability to earn an income by working, not the availability of work.

Reasonable medical treatment

7.12. Reasonable medical treatment is the treatment which a claimant would be reasonably expected to undergo in order to improve the condition. Reasonable medical treatment refers to care that is:

7.12.1. medically necessary;

7.12.2. likely to improve the claimant's condition, relieve symptoms or prevent deterioration; and

7.12.3. appropriate for the claimant's diagnosis according to accepted medical standards.

7.13. Refusal to undergo reasonable treatment the customer has been advised to undergo would mean that the claimant cannot be assessed for maximal medical improvement and permanence of the condition. It is understood that the duration of impairment for different diagnoses may vary, but permanence of the impairment can only be assessed after all reasonable treatment avenues have been pursued. Good record keeping practices should be implemented to record the claimant's consent or refusal of consent relating to treatment.

7.14. Temporary disability benefits might still be assessed, but adherence to recommended treatment plans or rehabilitation to assist the recovery process may still be required. This being said, South Africa's legal framework recognises the right of individuals to refuse medical treatment. The Constitution guarantees the right to bodily and psychological integrity. This right affirms the principle that individuals have the freedom to make informed choices about their healthcare, including the right to refuse treatment, even if it might put them at risk. However, the refusal of treatment can also lead to legal challenges, particularly when the claimant's decision is deemed unreasonable or when the treatment is deemed necessary for the claimant's health. The balance between patient autonomy and the duty of care in medical treatment is a critical consideration in such cases.

8. PRACTICAL APPROACH TO CLAIMS

8.1. The accompanying flow diagram at the end of this section is intended to serve as a summary of a practical approach which is recommended to be followed by psychiatrists and insurers in order to:

8.1.1. ensure objective reports to provide sufficient detailed information for the claimant to prove their claim;

8.1.2. make a fair decision on disability;

8.1.3. encourage consistency in the approach to psychiatric claim applications.

First line evidence (to be provided by the claimant)

8.2. A completed and singed, claim form from the insurer in question.

8.3. Information regarding qualifications and occupational history.

8.4. Vocational analysis, including the following:

8.4.1. job description, with details regarding the duties performed by the claimant on a daily basis;

8.4.2. work environment and circumstances under which duties are performed;

8.4.3. productivity reports and other collateral information from the employer;

8.4.4. relevant annual and sick leave records.

8.5. Detailed medical evidence supplied by the treating psychiatrist and other medical professionals consulted.

8.6. Any other supporting documentation required in terms of the claim form.

Second line evidence may include any of the following (to be obtained by the insurer if indicated)

8.7. Additional information or clarification of medical information provided by the treating psychiatrist.

8.8. Assessment and/or review by an independent psychiatrist and/or other health professional.

8.9. Functional capacity evaluation by an occupational therapist.

8.10. Any further information or clarification of existing information that may be deemed necessary, for example through a worksite visit.

Assessment process

8.11. Kindly refer to the flow diagram of the process below.

8.12. The assessment process is a dynamic and interactive one that requires analysis of data from various sources which includes many role players and stakeholders. Besides the claim assessor the claim may be assessed by a medical advisor or a legal advisor.

8.13. The final outcome of the assessment process in the event of a claim may include the following:

8.13.1. in the case of a lump sum benefit, a once-off payment;

8.13.2. in the case of an income replacement benefit (regular benefit payments), review and management of the claim on an on-going basis;

8.13.3. that the claim is declined;

8.13.4. that more information is requested at a later stage to re-evaluate the progression of the condition and to potentially establish maximum medical improvement.

8.14. The purposes of clause 8.13.2 include the following:

8.14.1. determination of the on-going validity of the benefit;

8.14.2. implementation and monitoring of active case management strategies, which may involve the treating psychiatrist and psychologist;

8.14.3. achieving return to work. This means returning to work either in full capacity or in a graded fashion with job accommodation in consultation with the employer, rehabilitation specialists and other relevant stakeholders;

8.14.4. assessing treatment programs, which may include both pharmacological and supportive therapies.

8.14.5. closely monitoring the adherence to recommended treatment.

Who pays for the clinical reports?

8.15. The initial onus to prove disability lies with the claimant. Therefore, the claimant should be liable for the accounts of all first line evidence, as described above, in order to establish causation and prove the severity of the impairment. It must also demonstrate that the condition causes limitations that prevent the claimant from performing past work or other work. This duty is ongoing and requires the claimant to disclose any additional related evidence about which he/she becomes aware throughout the review process.

8.16. The insurer should be liable for second line evidence, as described above.

8.17. In practical terms, this means that the claimant should pay the general practitioner and the treating psychologist and/or psychiatrist for the initial medical documentation and the insurer should pay for further documentation.

Tariff structure

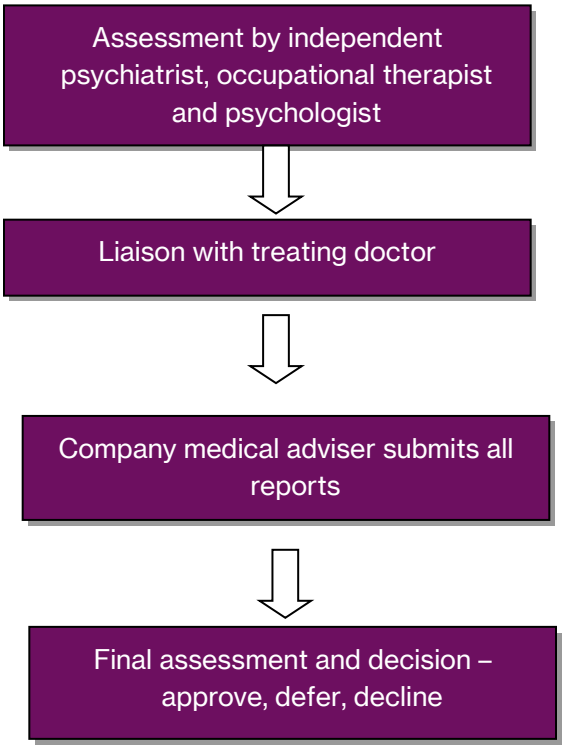
8.18. The fee for psychiatrists dealing with disability claims should be negotiated with each individual insurer.

Compensation for Occupational Injuries and Diseases Act 130 of 1993

8.19. The Compensation for Occupational Injuries and Diseases Act ("**COIDA**") provides a framework for compensating employees for disabilities caused by occupational injuries and diseases. COIDA aims to ensure that employees receive compensation for disablement sustained in the course of their employment. Disability assessment by the Compensation Commissioner is conducted according to the rules and regulations of COIDA and the criteria are different from the criteria applied by the insurance industry in assessing disability.

8.20. Accordingly, even though an employee may qualify for compensation under COIDA, it does not mean that the employee will meet the criteria for disability in terms of an insurance policy.

Flow diagram


Assessment by independent psychiatrist, occupational therapist and psychologist
Liaison with treating doctor
Company medical adviser submits all reports
Final assessment and decision – approve, defer, decline

DOCUMENT HISTORY

Date	Publication/amendment
1995	First edition published in medical journal by the Life Offices Association
2002	Second edition published by the Life Offices Association
2017	Third edition published by ASISA
March 2026	General review and updated from a competition law perspective

RESPONSIBLE SPA AND COMMITTEES

Responsible Board Committee	Life and Risk Board Committee
Responsible Standing Committee	Claims Standing Committee Medical & Underwriting Standing Committee
Responsible Senior Policy Advisor	ASISA Point Person to the Life and Risk Board Committee