FAMILY RESPONSIBILITY RIDER BENEFIT – DEATH CLAIM (DECLARATION BY DOCTOR)

INSURANCE NAMIBIA

The Professional Provident Society Holdings Trust No IT 312/2011(PPS Holdings Trust) is a Registered South African Trust
Professional Provident Society Insurance Company Limited Reg No. 2001/017730/06 ("PPS Insurance")
Professional Provident Society Insurance Company (Namibia) Limited Reg. No. 2003/122 ("PPS Insurance (Namibia)") – PPS Insurance is an Administrator of PPS Insurance (Namibia).

NOTE *To be completed by the treating Medical Attendant only.*

Please answer all the questions in full to ensure a timeous and complete assessment of your client's claim.

PPS obtained prior written consent from the life insured in terms whereof additional information pertaining to the claim may be provided. PPS Insurance Namibia will always do its utmost to prevent any unauthorised disclosure of your patient's personal information. PPS will adhere to any laws governing the protection of (and access to) personal information; and will not use the information for any purpose not provided for in the PPS Policy Contract.

Please fax the fully completed form to PPS Insurance Namibia Claims +264 (0)61 411 330 or email to namibiaclaims@pps.co.za

PART A: MEMBER DETAILS

Member number:

Initials: Surname:

Date of birth: D D / M M / Y Y Y Y

Email:

Cellular: 0

PART B: DETAILS OF THE CLAIM

Particulars of the patient

Name:

Surname:

National ID number/Passport if no ID:

PART C: MEDICAL CONDITION

1. Cause of death:
2. Contributory causes of death (if applicable):
3. Date of death: D D / M M / Y Y Y Y
4. Provide **date of initial consultation** and brief details of the **chronological history** of the condition, resulting in the death, or sequence of events:

5. Treatment or investigations conducted in respect of cause of death and contributory cause(s) of death:
   NOTE Please attach copies of all relevant investigations conducted.

Date	Details	Doctor

PART D: MEDICAL PRACTITIONER'S DETAILS

HPCNA Reg No: | | | | | | | | | | | Practice No: | | | | | | | | | | |

Surname: Initials:

Telephone No: Fax No:

Email Address:

Address:

Signed at this day of 20

Signature of Medical Attendant