CLAIM FOR SICKNESS BENEFIT NAMIBIA (DECLARATION BY MEDICAL DOCTOR / DENTIST)



The Professional Provident Society Holdings Trust No. 1T 312/2011(PPS Holdings Trust) is a Registered South African Trust. PPS Insurance Company (Namibia) Limited Reg. No. 2003/122. PPS Insurance Company Limited Reg. No. 2001/017730/06.

PPS Insurance Company Ltd is an Administrator of PPS Insurance Company (Namibia) Ltd.

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 patients claim PPS Insurance (Namibia) obtained prior written consent from the life insured in terms whereof additional information pertaining to the claim may be provided.

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: PARTICULARS OF PATIENT												
Surname:					Initials:							
Date of birth: (dd/mm/yy):	M M / Y Y	У Оссі	upation prior to	o the sickness:								
PART B: CLAIM DETAILS												
1. TOTAL BENEFITS: The patient was unable	to perform ANY profession	onal duties fr	om:									
Start date: D D / M M / Y 1	YYY	End date:	D D /	M M /	YYYY							
NOTE To qualify for <u>Total benefits</u> your paties their above occupation, whether physical or not as dealing with queries.			-		-							
2. PARTIAL BENEFITS: The patient was able	to perform SOME profess	ional duties f	from:									
Start date: D D / M M / Y <th< td=""></th<>												
NOTE To qualify for Partial benefits your patie working hours compared to normal working h	-		-									
3. When did your patient resume his / her us				mic with the t	secupation and profession.							
D D / M M / Y Y Y Y												
4. If your patient has not returned to work, please indicate the expected return to work date:												
Full time: DD / MM / YY	Y Y Part time:	D D /	M M /	YYY	Y							
PART C: PARTICULARS OF DIAGNOSIS, Please attach copies of all relevant invest		the claim.										
Diagnosis: Primary Diagnosis:	Initial date made:		ICI	O 10 code:								
Secondary Diagnosis:	Initial date made:		ICI	O 10 code:								
	Slowly progressive		<u> </u>									
5. Did the condition have: an acute onset?6. Provide date of initial consultation and br			of the condition	on or coguence	o of avents:							
6. Provide date of initial consultation and br	lei details of the chronolo	gicai ilistory	Of the condition	on, or sequence	e or events.							

7. Date(s) of follow-up consultatio	ITS.		
3. Which side of the body is affecte	ed? Left: Right: Both:	Not applicable:	
8.1 If affected, is it a dominant limb?	YES NO		
9. Is this claim due to an injury or t	raumatic event? YES NO		
9.1 If YES date of injury or event:	D D / M M / Y Y Y		
Please provide details in this regard (r	motorcycle accident, rugby injury, hijacking incid	dent, etc.)	
	ATMENT; RESPONSE TO TREATMENT A	ND ANTICIPATED FURTH	ER TREATMENT
10. Was any surgery / procedure pe			
Date of Surgery/Procedure:	D / M M / Y Y Y Y		
f yes, provide details:			
Nature of surgery: Open Surger	y: Laparoscopic Surgery:		
Were there any complications follow	ing surgery?		
s additional surgery/procedure anti	cipated? If yes, provide details (i.e. dates, natur	e of surgery):	
11. Details of treatment administer	ed for current illness or claim event including m	edication, physiotherapy and p	sychotherapy :
Name of medication/ therapy	Dose and frequency of treatment	Date commenced	Completion date
12. Is/has the patient been compli	ant with any treatment prescribed?	S NO	
	when treatment was stopped and / or alternati		

condition o				addition	TO THE A	above	WITHCH			i tilis		acity t		u wiia	- Carri		150116				a
14. Provide det this illness			sing ris	k factor	s e.g. ra	ised o	cholest	terol,	hyper	tensi	on, al	cohol	abuse	which	n may	have	led to	o the	develo	 opme 	ent of
PART E: GENE	RAL																				
15. Is it possib			sis mig	ht result	in any	form	of per i	man	ent in	capac	ity?			YES		NO					
16. Are you re If yes, describe t	he nature c	f the r	elations	ship?:	ES	N	0														
HPCNA Reg No	:								Pract	ice N	o: [
Surname:															ln	tials:					
Telephone No:									Fax N	No:											
Email Address:																					
Address:																					
Signed at							this					da	y of					20			
Signature of me	dical doctor	:																			

INFORMATION REGARDING THE DECLARATION BY MEDICAL DOCTOR/DENTIST FORM

PPS Insurance (Namibia) takes into consideration standard recovery periods for which any particular illness would, under normal circumstances, reasonably render a person unable to perform his/her professional duties. The standard recovery period are based on current clinical practice and research into relevant medical literature regarding treatment protocols and anticipated recovery periods. PPS Insurance (Namibia) will, however take into consideration aggravating factors influencing the recovery of the individual, when assessing a claim. In this regard, please provide relevant medical information which will assist PPS Insurance (Namibia) in its assessment of the claim.

Claims for sickness benefits must be made on the prescribed PPS Insurance (Namibia) claim forms.

Please note the following:

- 1) The treating medical practitioner / dentist must complete this form. Please note that PPS Insurance (Namibia) does not accept telephonic consultations and the policy rules require that the claimant should be personally examined by the attending medical practitioner.
- 2) The member must have consulted the treating medical practitioner within the first 7 days of the start of the claim period and the most recent consultation dates should be stated.
- 3) The Declaration by Medical Doctor / Dentist Form should cover the whole period claimed for. No post-dated forms will be accepted, except in the cases where PPS Insurance (Namibia) has authorised such request. PPS Insurance (Namibia) may, at its discretion, request weekly or monthly declarations to confirm diagnosis, treatment and progress.
- 4) In order to avoid conflict of interest, PPS Insurance (Namibia) will not allow Declaration by Medical Doctor / Dentist Forms to be signed by practitioners where there is a familial or other relationship between the physician and the policyholder except for the doctor/patient relationship. Where this is not the case PPS Insurance (Namibia) reserves the right to ask for any additional medical or other information that it may deem necessary in order to validate the claim.
- 5) Please note that whilst PPS Insurance (Namibia) values the contribution of psychologists, physiotherapists and occupational therapists in the treatment of patients, only medical doctors may book PPS Insurance (Namibia) members off work for PPS Insurance (Namibia) benefits
- 6) In determining whether the patient is booked off as 'Total' or 'Partial', please indicate on the form if the patient can perform any of his/her usual professional duties. Usual Professional Duties are defined as those occupational tasks which the patient is required to carry out as part of his/her occupation prior to claim. This may include administrative duties or tasks such as attending to electronic communication
- 7) No fee(s) will be paid by PPS Insurance (Namibia) for the completion and/or submission of this form. If you intend to levy a fee for the completion and/or submission of this form payment will have to be discussed and arranged directly with your patient.
- 8) PPS Insurance (Namibia) reserves the right to request further reports or consultation records should the need arise.

For further information please ask your patient to consult the PPS Insurance (Namibia) Provider Policy.