MEDICAL REPORTS FOR DEATHS – NAMIBIA

The Professional Provident Society Insurance Company (Namibia) Limited Reg. No 2003/122 is a registered long-term insurance provider regulated by the Namibia Financial Institutions Supervisory Authority. Any reference to PPS in this form means PPS Insurance (Namibia).

Estate Late:

National ID number/Passport if no ID:

IMPORTANT

- This **certificate is required in addition to the Registrar's Certificate of Death.**
- The medical practitioner should send it to PPS Insurance (Namibia) at namibiaclaims@pps.co.za / Fax: +264 (0)61 411 330
- PPS Insurance (Namibia) agrees to pay an internal agreed rate. The details are available from executor/beneficiary. For payment to be processed, we require a completed electronic fund transfers (EFT) form.

PPS Insurance (Namibia) claims:
E: namibiaclaims@pps.co.za
F: +264 (0) 61 411 330
Queries:
T: +264 (0) 61 411 300
E: namibiaclaims@pps.co.za
F: +264 (0) 61 411 330
Monday to Friday 07:30 to 16:30

PART A: DETAILS OF MEDICAL PRACTITIONER

I, the undersigned a registered medical practitioner.

National ID number/Passport if no ID:

Certify that the following facts are true and correct in respect of the death of the late (full name):

1. General

(a) Were you the deceased's family doctor? YES ☐ NO ☐

If yes, since what date? D D / M M / Y Y Y Y

(b) If not, please supply the name and address of the deceased's family doctor:

2. Details of death

(a) Date of death: D D / M M / Y Y Y Y

(b) Cause of death:

ICD 10 code:

(c) Contributory cause (if any):

ICD 10 code:

(d) Dates of first and subsequent consultations in respect of the disease that caused the death:

(e) Was the deceased informed of this diagnosis? YES ☐ NO ☐

(i) If YES, when was the condition first diagnosed? D D / M M / Y Y Y Y

(ii) Please provide the name and contact details of the medical practitioner that diagnosed the condition, if not diagnosed by you:

(f) State the nature of treatment from onset of the illness up to the date of death:

(g) Was an inquest held? YES ☐ NO ☐

If YES state if it was a private or judicial inquest?

3. Other diseases or complaints that the deceased consulted you about: nature of illness or complaint including treatment

Nature of illness or complaint	Treatment	Date of first and subsequent consultations

4. Consultations with other medical practitioners including specialists of which you are aware?

Name	Address	Phone	E-mail

5. Habits:

In your opinion, did the deceased ever suffer from one of the following? Provide details to those questions answered yes.

(a) Depression/anxiety YES ☐ NO ☐

(b) Alcohol abuse YES ☐ NO ☐

(c) Drug abuse YES ☐ NO ☐

(d) Did the deceased receive any treatment or therapy for any of the above? If YES, please provide details. YES ☐ NO ☐

MEDICAL PRACTITIONER'S DETAILS

HPCNA reg no: Practice no:

Surname: Initials:

Telephone:

E-mail address:

Address:

Signed at this day of 20

Signature of medical attendant