CRITICAL ILLNESS CLAIM FORM

(To be completed by the medical attendant)

Please note that Hollard Life will not be liable for any costs incurred in the completion of this form.

Return the completed form and the above documents to lifeclaims@hollard.co.za or fax to 086 659 0135.

1. Policy details

Policy no. _____ Identity no. _____

Name of insured _____

Occupation _____ Date of birth _____

Physical address _____

_____

1. Diagnosis of dread disease relevant to this claim

_____

_____

_____

_____

_____

2. The cause of the patient's dread disease

_____

_____

_____

_____

_____

3. Date of diagnosis D D M M Y Y Y Y

4. Was the patient informed of the diagnosis? YES ☐ NO ☐ If so, when? D D M M Y Y Y Y

5. When did the patient experience the earliest symptoms? D D M M Y Y Y Y

6. Details of complications or concurrent conditions

_____

_____

_____

7. a. Date of first consultation and treatment of the patient's present medical condition D D M M Y Y Y Y

_____

b. Date of last consultation and treatment of the patient's present medical condition D D M M Y Y Y Y

_____

Names, addresses and contact numbers of any other medical practitioners who may be or have been consulted

8. Details of any hospitalisations or special investigations

9. Full details of treatment from the date of the first consultation to the current date, the results and reasons, if any, for change

10. Details of any specialised treatment

11. a. Is there any reason to believe that the condition may have arisen in any way from AIDS or any HIV related infection?

b. Has the patient ever been tested for HIV antibodies?

c. If so, what was the result of the test?

12. Progress thus far and anticipated prognosis

13. Please provide any other information which may be useful to the company in assessing the claim

14. Please attach copies of investigations, laboratory tests, specialist reports (e.g. cancer: histology, heart attack: blood enzymes, R & E ECG, stroke: MRI scans).

I declare that I have personally attended the patient and that the aforementioned statements are correct to the best of my knowledge.

Name of doctor

Qualifications

Practice no. Tel. no.

Cell no. Fax no.

Email address

Postal address

Signature **Date** D D M M Y Y Y Y

Hollard Declaration

We respect and adhere to patient confidentiality and data privacy principles in relation to Personal Information. We will therefore only process this information for the purpose for which it is intended.