Critical Illness Claim Form

Hollard.

(To be completed by the medical attendant)

Please note that should there be any charges for the completion of this form, such charges will be for the life insured's account.

The following copies must be included when submitting this form along with any other pertinent information to this claim:

a. Diagnosis (e.g. cancer: histology; heart attack: blood enzymes, R & E ECG; stroke: MRI scans; cardiac surgery: angiogram, angiography reports)
b. Specialist reports
c. All investigations

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

1. Life assured details

Policy no. _____ ID no. _____

Name of insured _____

Occupation _____ Date of birth _____

Postal address _____

1.1. Diagnosis of dread disease relevant to this claim

_____

_____

_____

_____

_____

1.2. The cause of the patient's dread disease

_____

_____

_____

_____

_____

1.3. Date of diagnosis D D M M Y Y Y Y

1.4. Was the patient informed of the diagnosis? ☐ Yes ☐ No If so, when? D D M M Y Y Y Y

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

1.6. Details of complications or concurrent conditions

_____

_____

_____

1.7. a. Date of first consultation D D M M Y Y Y Y

b. Date of last consultation D D M M Y Y Y Y

c. Date on which treatment commenced? D D M M Y Y Y Y

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

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_____

_____

_____

1.9. Details of any hospitalisations or special investigations

1.10. Details of any treatments conducted or anticipated

1.11. Progress thus far and anticipated prognosis

1.12. Please provide any other information that may be useful to the company in assessing this claim

2. Declaration by medical attendant

I declare that I have personally attended to the patient and that this form has been completed to the best of my knowledge.

Full name

Qualifications

Practice no.

Work tel. no.

Cell no.

E-mail address Mandatory

Postal address

Signature

Date D D M M Y Y Y Y