Certificate of Continued Disability Claim Form

Hollard.

(To be completed by both life insured and medical attendant)

Please note that it is essential to complete this form in full to prevent unnecessary delays as a result of missing information.

The following must be included when submitting this form:

a. Any clinical evidence you may have in your possession
b. Tests results, reports and/or investigations

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

1. Life assured details

Name of claimant _____

Policy no. _____ ID no. _____

Date of birth D D M M Y Y Y Y Work tel. no. _____

Home tel. no. _____ Cell no. _____

E-mail address _____ Mandatory

Physical address _____

Postal address _____

2. Details regarding your injury/illness

1.1. What work have you done since Hollard Life started paying your benefit?

Type of work	From when	To when	Amount paid	How has your illness/injury made it difficult for you to do this work?

1.2. Have you received payment from any of the following sources?

	Yes/No	Amount received	Lump sum or monthly payment?	Payment made from (date)	Payment made to (date)
Workmen's compensation (WCA/COID)					
Unemployment Insurance Fund (UIF)					
Third party claim					
Any other insurance benefit					
Commission					
Other (please specify)					

1.3. Describe in your own words your medical problem/injury or complaints

_____

_____

_____

_____

_____

_____

1.4. Are you able to do any of the following?

	When/How often	For how long	What makes it difficult for you to do this?
Shopping			
Driving			
Gardening			
Housework			
Watching television			
Visiting family and friends			

1.5. If you were given a chance to learn a new job or skill that would help you earn an income, what job would you like to do (e.g. computer training, woodworking, sewing, etc.)? Please consider your illness/injury when answering this question.

Signature
(life insured) _____ **Date** D D M M Y Y Y Y

Name and address of witness _____

_____ Code _____

3. To be completed by the life assured's 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.

Dear Doctor
Hollard Life is currently reviewing an existing disability claim in respect of this member and would appreciate your completing this confidential medical report.

It is essential that you complete this form as fully as possible.

Note: If you have any reports of previous investigations to substantiate diagnosis, please supply copies thereof. The purpose of this report is to assess the claimant's impairment and to ascertain:

a. alteration(s) of functional capacity due to illness or injury;
b. diagnosis;
c. optimal medical treatment.

4. Life assured's personal details

Full Name _____

Date of birth D D M M Y Y Y Y

5. Medical information

1.1. If you are still attending to the life assured, when was the last consultation? D D M M Y Y Y Y

1.2. Complete the schedule below

Date	Reason for consultation	Diagnosis	Treatment	Result

1.3. Was the life assured referred to any other practitioner? ☐ Yes ☐ No

If yes, supply details _____

1.4. Was the life assured hospitalised? ☐ Yes ☐ No

1.5. Give details of any admissions to hospital and/or referrals to any other specialist(s) in connection with the life assured's disablement during the past 12 months

Date		Hospital/Doctor	Tel. no.	Treatment and result
From	To			

1.6. Describe the life assured's compliance with treatment

1.7. Describe fully the nature and extent of the life assured's impairment, i.e. current signs and symptoms, severity and prognosis.

1.8. Provide any additional information, that you feel will help in the assessment of this claim. If there is not enough space on this form, continue on a separate sheet.

6. 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