General Practitioner's Report

To be completed by the patient's usual Family Doctor, who has known the patient for two years or longer

Note: This page is only to be completed where the policy is less than 24 months old, the patient was added to the policy less than 24 months ago or where the benefits have been increased in the last 24 months

Please note that the responsibility for payment of any expenses for the completion of this form is to be borne by the claimant and not Hollard Life

Policyholder:
Policy Number: _____Reference Number: _____

Full names: _____

Date of birth/Identity number: _____

Patients Details:
Full names: _____

Date of birth/Identity number: _____

Place of hospitalisation: _____

Date of admission: _____

Date of discharge: _____

Medical Details:
Are you the regular medical attendant? _____

If no, please state name and address of usual medical attendant: _____

For how long have you known the insured person? _____

Reason for hospitalisation? _____

When did the patient first consult you for this condition? _____

When did the patient become aware of the illness? _____

Has the patient suffered from this condition before? If so, provide dates and details of treatment below:

Date	Details of treatment

Has the patient's hospital confinement resulted from any of the following?

Childbirth, pregnancy or hysterectomy? _____

The influence of any drug not administered on the advice of a doctor _____

Alcohol addiction? _____

Suicide or self-inflicted injury? _____

Cosmetic or plastic surgery? _____

Congenital conditions or childhood disease? _____

Mental disease or disorder? _____

Hazardous pursuits e.g racing, flying, military/policy duty or war? _____

Date of accident _____

Details of accident _____

_____

Injuries sustained _____

_____

Details of all previous consultations

Date of consultation	**Reason for consultation, diagnosis, treatment and results**

Please state any information not already mentioned which might be relevant to the assessment of this claim

_____

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_____

_____

I hereby certify that the patient, as named in this form, was suffering from the injuries/illness referred to in this form and I know of no circumstances,
other than the mentioned above, which might affect the assessment of the claim, if any, in respect of the patient
Signed a