|  |
| --- |
| **(To be completed by usual medical attendant)** |

|  |
| --- |
| **Please note that it is essential to complete this form in full to prevent unnecessary delays as a result of missing information.****Please note that should there be any charges for the completion of this form, such charges will be for the claimant's account.****Return the completed form and the above documents to** lifeclaims@hollard.co.za **or fax to 086 659 0135.** |

|  |
| --- |
| Life assured details |

|  |  |  |  |
| --- | --- | --- | --- |
| Policy no. |   | ID no. |   |
| Name of insured |   |
| **Date of birth**  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |  Date of death |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
| Place of death |   |  Duration of illness if natural causes |   |
| Provide full details of the cause of death (‘natural causes’ or ‘unnatural death’ is not sufficient – state the circumstances leading to death) |
|   |
|  |

|  |  |  |
| --- | --- | --- |
| a. Are you the usual medical attendant of the deceased? | [ ]  Yes | [ ]  No |
|  If yes, how long have you known him/her? |   |
|  If no, supply the name, address and telephone number of the usual medical attendant |
|   |
|   |
|   |

|  |  |  |
| --- | --- | --- |
| Was the death as a result of illness? | [ ]  Yes | [ ]  No |
|  If yes: |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Date when the deceased first became aware of it or any symptoms
 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
| 1. Date when the illness was diagnosed
 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
|  State any disease or conditions which preceded or co-existed with the immediate cause of death and the date of diagnosis |
|  Condition |   |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
|  Condition |   |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
|  Condition |   |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
|  Condition |   |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
|  Indicate any other complaints for which the deceased consulted you and date of diagnosis |
|  Condition |   |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
|  Condition |   |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
|  Condition |   |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
|  Condition |   |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
| Was the death as a result of an accident? | [ ]  Yes | [ ]  No |

|  |
| --- |
|  If yes: |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. When did you first attend to the deceased with regard to the injuries sustained in the accident?
 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
| 1. Give full details of the nature of the injuries sustained by the deceased
 |
|   |
|   |
|   |
| a. Has the deceased ever been tested for HIV antibodies? | [ ]  Yes | [ ]  No |
|  If yes, what was the result of the test and when was it done? |
|   |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

 |
| Indicate the names and addresses of any other doctor(s) consulted by the deceased during the past 5 years, other than these mentionedabove |
|   |
|   |
|   |
|   |
| Did the deceased use tobacco in any form? | [ ]  Yes | [ ]  No |
| Was an inquest or post mortem inquiry held? | [ ]  Yes | [ ]  No |
| Provide any other relevant facts relating to the deceased’s medical history or habits |
|   |
|   |
|   |

|  |
| --- |
| 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 |   |
| Postal address |   |
|  |
| **Signature** |  |  **Date** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y | Y | Y |

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