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

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| **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.** |

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| Life assured details |

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| 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) | | | | | | | | | |
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| 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 | | | | |
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| Was the death as a result of illness? | Yes | No |
| If yes: | | |

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| 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 |

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| If yes: |

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| 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 | | | | |
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| 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? | | | | |
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| Indicate the names and addresses of any other doctor(s) consulted by the deceased during the past 5 years, other than these mentioned  above | | | | |
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| 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 | | | | |
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| Declaration by medical attendant |

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| 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 | |