

DISABILITY REVIEW: MEDICAL ATTENDANT'S REPORT

Please return to: ZBotma@hollardnam.com

SECTION A: WHEN TO COMPLETE THIS FORM

Hollard is currently reviewing an existing disability claim and requires the claimant's medical attendant to complete this form to provide us with the clinical history and up-to-date medical information since the date of the previous report issued by the medical attendant. No clinical examination is necessary.

It is essential that this report is fully completed to prevent unnecessary delays due to missing or incomplete information. The medical attendant may submit this report together with the account to Hollard Life on the above contact details.

This form is structured in six sections:

- Section A: When to complete this form (informative section)
- Section B: Policy details (to be completed by employer or claimant)
- Section C: Claimant's personal details (to be completed by employer or claimant)
- Section D: Medical Attendant's Details (to be completed by medical attendant)
- Section E: Medical Information (to be completed by medical attendant)
- Section F: Declaration (to be signed by medical attendant)

This fully completed form should be accompanied by the following supporting documentation:

- copies of any reports (e.g. EEG, X-rays, previous consultations, etc.)
- copies of any laboratory results (e.g. histology, blood results (including CD4 counts), etc.)
- copies of any additional information

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Life.

PRIVACY

We respect the confidentiality of your personal and medical information. If necessary, we may need to share either your personal or medical information, or both, with third parties. These third parties are other insurance and or reinsurance companies, or service providers that may assist us in assessing and managing the risk, or servicing you. We impose the same strict confidentiality standards on these third parties as is applied by us.

By providing the required personal and medical information, and signing this declaration of health, you hereby confirm that you consent to us processing and sharing your personal and medical information with other third parties.

SECTION B: POLICY DETAILS (to be completed by employer or claimant) Employer:

Policyholder:	
Policy number:	
Disability income benefit claim number:	

SECTION C: CLAIMANT'S PERSONAL DETAILS (to be completed by employer or claimant) First

names:	
Surname:	
Identity number:	
Date of birth:	D D M M Y Y Y Y
Gender:	M F

Code:

Code:

[illegible]

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Title: First names:

Code:

Code:

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[illegible][illegible]

1. What was the date of the last report you submitted in respect of this claimant (if any)?

D

D

M

M

Y

Y

Y

Y

D D M M Y Y Y Y

D D M M Y Y Y Y

Therapy / Medication

5. Please describe the nature of the claimant's disability including current symptoms, conditions and treatment.

6. Please provide details of any admission to hospital and/or other doctors or specialists who have been consulted in connection with the claimant's disability.

Date	Doctor/Specialist/Hospital	Address	Telephone number

7. Has the condition been continuous since the date the claimant was first absent from work?

Y	N
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If "No", please state the extent to which the claimant has been able to work in any capacity.

8. Please provide details regarding the dosage, duration and compliance to treatment by completing the table below.

Treatment	Dosage	Duration	Compliance

9. Please provide details regarding the response and side effects to treatment by completing the table below.

Treatment	Response	Side effects

10. Have any changes been made to the treatment regime?

Y	N
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If "Yes", please provide full details/reasons for the change and the response to new treatment.

11. Is any further treatment planned or anticipated?

Y	N
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If "Yes", please provide full details of treatment.

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12. What is the claimant's occupation?

13. In your opinion, as at what date was the claimant last able to work?

14. In your opinion when will the claimant be able to engage in any part of his/her occupation in a:

a) Part-time capacity?

b) Full-time capacity?

15. If the claimant has already recovered and returned to work, please provide the date of his/her return to work:

16. In your opinion, what is preventing the claimant from engaging in his/her occupation?

17. Is the claimant undergoing any form of rehabilitation?

If "No", would you recommend any rehabilitation? Please provide details.

18. Please provide any additional information, which can be of assistance in the review of this disability claim.

Thank you for your assistance. We wish to advise that we may be requested to provide a copy of this report to other medical and supplementary health practitioners, other insurers and/or legal representatives.

SECTION F: DECLARATION (to be signed and dated by medical attendant)

I hereby declare that I have personally examined and attended to the claimant and that the contents of this report are true and correct. I accept that a copy of this report can be made available to other parties as stated above.

Signed at on this day of 20

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Name of the medical attendant

Signature