

## CRITICAL ILLNESS BENEFIT - ACTIVITIES OF DAILY LIVING FORM

The information provided in this form will be used by Hollard Group Risk in the assessment of the member's application for critical illness benefits.

This form must be completed by a registered medical practitioner or occupational therapist (who is not a member of the member's immediate family). As this form is in support of a claim application, any cost in connection with it will be for the account of the policyholder / member.

Please submit the completed form to [hgrdisability@hollard.co.za](mailto:hgrdisability@hollard.co.za) or post it to PO Box 87419, Houghton 2041 (attention Hollard Group Risk Disability claims). Our contact number is 011 351 5000.

The request for completion of this form in no way constitutes an admission of liability by Hollard Group Risk.

### SECTION A: POLICY DETAILS (to be completed by the member)

Employer:

Policyholder:

Policy number:

Membership / Employee number:

### SECTION B: MEMBER'S PERSONAL DETAILS (to be completed by the member)

First names:

Surname:

Identity number:

Date of birth (dd/mm/yyyy):

Gender:

Male

☐

Female

☐

### SECTION C: MEDICAL ATTENDANT'S DETAILS (to be completed by the medical attendant /occupational therapist)

Full name and surname:

Qualifications:

Practice number:

Physical address:

Code:

Contact number:

Email address:

**SECTION D: MEDICAL INFORMATION** (to be completed by the medical attendant /occupational therapist)

*Dear medical attendant, thank you for your assistance in completing this form. Kindly note that Hollard Group Risk may be required to provide a copy of this report to other medical practitioners, other insurers and/or legal representatives.*

Please complete tables below indicating the member's ability to complete the activities listed:

**BASIC ACTIVITIES OF DAILY LIVING**

**ABLE      UNABLE**

1. **Bathing**, the ability to wash/bathe oneself independently
2. **Transferring**, the ability to move oneself from a bed to a chair or from
3. **Dressing**, the ability to take off and put on one's clothes independently
4. **Eating**, the ability to feed oneself independently. This does not include the making of food
5. **Toileting**, the ability to use a toilet and cleanse oneself thereafter independently
6. **Locomotion on a level surface**, the ability to independently walk on a flat surface
7. **Locomotion on an incline**, the ability to independently walk up a gentle slope, or a flight of steps

**ADVANCED ACTIVITIES OF DAILY LIVING**

**ABLE      UNABLE**

1. **Driving a car**, the ability to open a car door, change gears or use a steering wheel
2. **Medical care**, the ability to prepare and take the correct medication
3. **Money management**, the ability to do one's own banking and to make rational financial decisions
4. **Communicative activities**, the ability to communicate (verbally or written)
5. **Shopping**, the ability to choose and lift groceries from shelves as well as carry them in bags
6. **Food preparation**, the ability to prepare food for cooking as well as using kitchen utensils
7. **Housework**, the ability to clean a house or iron clothing
8. **Moderate activities**, activities like moving a table, pushing a vacuum cleaner, etc
9. **Vigorous activities**, the ability to partake in running, heavy lifting, similar sports
10. **Community ambulation** with/ without assistive device, not requiring a mobility device, the ability to walk around in public using only a walking stick if necessary

**SECTION E: DECLARATION** (to be signed and dated by medical attendant/occupational therapist)

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

Signed at  on this  day of  20

Signature