CRITICAL ILLNESS BENEFIT CLAIM FORM – MEDICAL ATTENDANT'S REPORT

Dear Doctor,

The medical information requested in this form is in support of a claim for critical illness benefits provided by the member's employer through Hollard Group Risk. The information you provide is vital in the assessment of the claim. Given this is a highly stressful experience for the member, we kindly request your prompt assistance with the matter. It is essential that this form is fully completed, signed and dated to prevent any unnecessary delays.

As this form is in support of a claim application, any cost in connection with this form will be for the account of the policyholder / member.

Please ensure that copies of all clinical / diagnostic test results and relevant reports are submitted with this form (as per Annexure One – Critical Illness Benefit).

The information should be submitted to Hollard Group Risk, hgrdisability@hollard.co.za or posted to PO Box 87419, Houghton 2041 (attention Hollard Group Risk Disability claims). Our contact number is 011 351 5000.

We thank you in advance for your help.

SECTION A: MEMBER'S DETAILS (to be completed by the member)

Employer's name:

Member's full name(s) and surname:

Identity number (or passport number):

Date of birth (dd/mm/yyyy):

SECTION B: MEDICAL ATTENDANT'S DETAILS (to be completed by the medical attendant)

Doctor's full name(s) and surname:

Qualifications / speciality:

Hospital / practice number:

Physical address:

Code:

Contact number:

Email address:

SECTION C: MEDICAL REFERENCES (to be completed by the medical attendant)

Please give the details of any other medical practitioners that the member has been referred to:

Name of practitioner(s):		
Speciality:		
Contact number:		
Reason for referral:		
Date referred:		

SECTION D: CRITICAL ILLNESS DETAILS (to be completed by the medical attendant)

Member's diagnosis(es):	Date of diagnosis(es)

Select which of the following conditions accurately describes the member's condition(s) by ticking the applicable critical illness(es):

- ☐ Heart attack
- ☐ Coronary artery bypass graft
- ☐ Stroke
- ☐ Cancer
- ☐ Kidney failure
- ☐ Loss of limbs
- ☐ Major burns
- ☐ Alzheimer's disease
- ☐ Accidental HIV
- ☐ Surgical repair for any structural defects of the heart
- ☐ Total blindness
- ☐ Coma
- ☐ Multiple sclerosis
- ☐ Major organ transplant
- ☐ Motor neuron disease
- ☐ Parkinson's disease
- ☐ Benign brain tumour

ICD10 code(s) relating to the member's diagnosis / diagnoses:

Please elaborate on the cause / nature of the member's condition as indicated above.

Does the member have a history of this condition? If "Yes", please provide details:

☐ Yes ☐ No

Please comment on the member's treatment.

Treatment start date:

Please note any other illness or injury for which the member consulted you.

Injury / Illness:	Date:

SECTION E: PRIVACY

We respect the confidentiality of your personal information as well as your privacy. If necessary, we may need to share either your and/or the member's 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 service delivery. 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 form, you hereby confirm that you consent to us processing and sharing the personal and medical information with other third parties. We will treat this information with caution and we have put reasonable security measures in place to protect it. The information provided will only be used for its intended purpose and will not be shared within the Hollard Group or another organisation for marketing additional products and/or services to you.

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

I declare / confirm that:

- I have personally examined and attended to the member.
- The answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Group Risk.
- A copy of this report can be made available to other parties as stated above.
- I have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information.
- If I agree to the aforementioned on behalf of someone else, I have the necessary approval and/or mandate to do so.

If this claim or any supporting claim documentation is found to be fraudulent or misrepresented, Hollard Group Risk reserves the right to proceed with the appropriate action against the member.

Signed at _____ on this _____ day of _____ 20 _____

_____

Doctor's signature

Hollard is committed to "Creating and securing a better future" and therefore subscribes to an internal Anti-Fraud policy. Please report any suspicious or unethical activity anonymously on 0801 516 170 (toll free) or via email at Hollard@tip-offs.com.