DISABILITY CLAIM FORM – MEDICAL ATTENDANT'S REPORT

Please return to: Hollard Group Risk, Florence House, 22 Oxford Road, Parktown 2193 or PO Box 87419, Houghton 2041.
Tel: (011) 351 5000. Email: hgrdisability@hollard.co.za

The member must obtain at their own expense, the medical attendant's report from a registered doctor (hereafter referred to as the medical attendant), who is not a member of the member's immediate family. The medical attendant must complete this form for us to ascertain the diagnosis, changes in functional capacity due to illness or injury, optimal medical treatment and to assess the member's degree of medical impairment.

It is essential that this form is fully completed to prevent any unnecessary delays due to missing or incomplete information. This form may be submitted to Hollard Group Risk by the employer, member or the medical attendant.

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

- copies of any reports and diagnostic results (e.g. scans, X-rays, previous consultations, etc.)
- copies of any laboratory results (e.g. histology, blood results, etc.)
- copies of any additional information to substantiate the claim

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

PRIVACY STATEMENT

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 insured'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 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 form, you hereby confirm that you consent to us processing and sharing your 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 A: POLICY DETAILS (to be completed by the employer or member)

Employer:

Policyholder:

Policy number:

Membership / Employee number:

SECTION B: MEMBER'S PERSONAL DETAILS (to be completed by employer or member)

First names:

Surname:

Identity number:

Date of birth:

Gender:

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

Title: First names:

Surname:

Qualification:

Practice number:

Physical address:

Code:

Telephone number:

Email address:

SECTION D: MEDICAL INFORMATION (to be completed by medical attendant)

Diagnosis:	Date of diagnosis (dd/mm/yyyy):

3. Date the symptoms started:

4. Date of the first consultation:

5. Date of the last consultation:

6. Provide the member's:

Height: cm

Weight: kg

Blood pressure:

7. What caused the member's condition?

8. What are the resultant limitations experienced by the member?

9. Indicate how the condition affected the member's ability to perform activities of daily living:

	Able	With help	Unable
Mobility: The ability to move indoors from room to room on level surfaces.	☐	☐	☐
Transferring: The ability to move from a bed to an upright chair or wheelchair and *vice versa.*	☐	☐	☐
Eating: The ability to feed oneself once food has been prepared and made available.	☐	☐	☐
Washing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.	☐	☐	☐
Dressing: The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	☐	☐	☐
Toileting: The ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate. The maintenance of continence is included in this activity of daily living although it may be regarded as an activity of daily living on its own.	☐	☐	☐

10. Please provide details of any complications or concurrent conditions:

11. Are you still attending to the member? Yes ☐ No ☐

12. Does the member have insight into their condition? Yes ☐ No ☐

If "No", please provide details:

13. Please provide details of all consultations in the last five years:

Date	**Reason for consultation**

14. Has the member ever been hospitalised for this or any other conditions? Yes ☐ No ☐

If "Yes", please provide details of hospitalisation:

Date admitted	Date discharged	Reason	Name of hospital

Please provide details of the treatment received during the hospitalisations mentioned above:

Name of hospital	Treatment	Outcome

15. Has the member undergone any special / diagnostic investigations, e.g. scans, tests, etc? Yes ☐ No ☐
If "Yes", please provide details:

Date	Special investigation	Outcome

16. Has the member been referred to any other health care professionals? Yes ☐ No ☐
e.g. Physiotherapist, Occupational Therapist, Psychologist or other medical specialists, etc.

If "Yes", please provide details:

Name	Specialty	From	To	Outcome of treatment

17. Has any of the following contributed in any way to the member's condition?

	Yes	No	Details
Accident:	☐	☐	
HIV:	☐	☐	
Previous illness or injury:	☐	☐	
Hazardous pursuit or pastime:	☐	☐	
Habits e.g. excessive alcohol consumption:	☐	☐	
Self-inflicted injuries:	☐	☐	

18. Please provide details regarding the member's treatment by completing the table below:

Date	Therapy / Medication	Description / Dosage

	Yes	No	Details
Is the member complaint with medication / therapy?			
Is the condition satisfactorily controlled?			
Is current therapy optimal?			
Is future surgery planned or required? If “Yes” please advise when in the "Details" section.			

Any additional comments:

19. Please provide an indication of the short-term prognosis with reasons:

20. Please provide an indication of the long-term prognosis with reasons:

21. Please complete the assessment scale below to describe the nature of the member's impairment.
Complete section 21.1 and either section 21.2 or 21.3.
Select only the most appropriate response.

21.1 COMPULSORY SECTION:

21.1.1. Sensory Motor Abilities

(a) Vision and hearing

☐ The member's vision and/or hearing abilities, with the use of assistive devices, are not reduced to the extent that physical assistance from another person is required.

OR

☐ The member's vision and/or hearing abilities are reduced to the extent that functional abilities are affected and independent functioning without physical assistance from another person in a workplace is impossible, even with the use of assistive devices.

OR

☐ The member is entirely functionally blind or deaf.

(b) Speech

☐ The member's speech abilities, with the use of assistive devices, are not reduced to the extent that physical assistance is required.

OR

☐ The member's speech abilities are reduced to the extent that verbal communication within a workplace requires physical assistance, both through another person and an assistive device.

OR

☐ The member is entirely unable to verbally communicate within a workplace, despite physical assistance through another person and an assistive device.

21.1.2. Mobility

☐ The member is able to move independently between essential workstations with, at the most, the assistance of a walking cane or other assistive device (including a wheelchair).

OR

☐ The member requires partial physical assistance, from another person, even with the use of support apparatus and a walking cane or other assistive device (including a wheelchair), in order to move between essential work stations.

OR

☐ The member requires constant physical assistance, from another person, for mobility between essential workstations, despite the workplace meeting the legislative requirements for accessibility.

21.1.3. Cognitive impairment

☐ The member's cognitive ability is unimpaired regardless of any presence of irreversible cognitive deterioration or damage that is organic in nature.

OR

☐ The member medically requires periodic assistance or direct supervision to perform work tasks, due to deterioration in or damage to cognitive ability, as measured by clinical evidence and standardised tests that is irreversible and organic in origin.

OR

☐ The member medically requires constant assistance to perform work tasks, due to deterioration in or damage to cognitive ability, as measured by clinical evidence and standardised tests, that is irreversible and organic in origin.

OR

☐ The member is totally unable to perform work tasks despite constant assistance, due to cognitive deterioration or damage, as measured by clinical evidence and standardised tests, that is irreversible and organic in origin.

21.2 COMPLETE ONLY IF APPLICABLE: PROFESSIONAL / WHITE COLLAR WORK DUTIES

21.2.1. Work stamina

☐ The member is able to meet the full (i.e. 75% to 100%) effort tolerance and endurance requirements, with regular breaks.

OR

☐ The member is able to meet 40% to 75% requirements for effort tolerance and endurance, with prolonged rest periods, the use of good ergonomic principles and assistive devices or support system.

OR

☐ The member is able to meet at most 40% requirements for effort tolerance and endurance, despite prolonged rest periods, the use of good ergonomic principles and assistive devices or support system.

21.2.2. Co-ordination and dexterity

☐ The member is able to use both upper limbs in a coordinated and dexterous manner in order to perform gross and fine motor work activities.

OR

☐ The member is able to perform gross motor work activities, albeit in an awkward fashion, but requires physical assistance from another person to perform fine motor work activities, despite appropriate adaptations and assistive devices.

OR

☐ The member is unable to perform gross and fine motor work activities despite appropriate adaptations, the use of assistive devices and physical assistance from another person.

21.3 COMPLETE ONLY IF APPLICABLE: MANUAL / BLUE COLLAR WORK DUTIES

20.3.1. Physical capabilities

☐ The member is able to move through the full range of dynamic work postures, with at the most the assistance of a walking cane or other ambulatory device.

OR

☐ The member is able to move through a partial range of dynamic work postures but requires physical assistance from another person, in conjunction with a suitable assistive and/or ambulatory device, and requires a prolonged time period.

OR

☐ The member is totally reliant on physical assistance from another person, despite use of suitable assistive and/or ambulatory devices, to move between all the dynamic work postures.

22. In your opinion, when was the member last able to work?

23. In your opinion when will the member be able to perform any part of their occupation in a:

(a) Part-time capacity?

(b) Full-time capacity?

24. If the member has already recovered, please provide the return to work date:

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

Thank you for filling out the form.

By signing this form, you declare that:

- the content of this form is true to the best of your knowledge and that you have not withheld any material facts from Hollard Group Risk.
- a copy of this report can be made available to third parties (e.g. other medical practitioners, other insurers and/ or legal representatives) for the purposes of assessing and managing the member's claim.
- in the event that 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.
- you have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information.

Signature

Date signed

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.