fin
HOME LOANS

DISABILITY CLAIM

TO BE COMPLETED BY THE MEDICAL ATTENDANT

DETAILS OF INSURED

Policy Number ____

Name of Patient____

Date of Birth (DDMMYY) ____

Address ____

____ Postal code __________

Occupation__________________________________

Employer___________________________________

Employer's telephone number(______)_____________

KINDLY PROVIDE US WITH THE FOLLOWING INFORMATION

1. Diagnosis of patient's condition

   ____
   ____
   ____

2. The cause of patient's disability

   ____
   ____
   ____

3. Date of diagnosis (DDMMYY)
4. Was the patient informed of the diagnosis?
5. When did the patient experience the earliest symptoms hereof?______________________
6. Details of complications or concurrent conditions________________________________

a) Date of first consultation and treatment with regards to the patient's present medical condition.

   ____

b) Date of last consultation and treatment with regards to the patient's present medical condition

   ____

7. Name, addresses and contact numbers of any other medical practitioners who may or have been consulted

____
____
____

8. Details of any hospitalisations or special investigations

----

9. Full details of treatment from the date of first consultation to the current date, the results, and the reasons, if any , for change

____
____
____
____

10. Details of any specialised treatment

____
____
____
____

11. (a) Is there any reason to believe that the condition may have arisen in any way from AIDS or any HIV infection?

____

(b) Has the patient ever been tested for HIV antibodies?______________________________

(c) if so, what was the result of the test?____

12. Progress thus far and anticipated prognosis

____
____
____
____
____
____

13. Please provide details of other information, which may be useful to the company assessing this claim etc.

____
____
____
____
____

14. Please provide us with copies of all investigations, laboratory test, specialist reports etc.
____
____

IMPAIREMENT is the alteration of normal functional capacity, that is, which functions is the person still able to do and which not, due to disease, and is assessed by medical means, after a diagnosis has been established , and appropriate and optimal treatment applied.

DISABLITY is the alteration of capability to meet the personal, social or occupational demands due to an impairment, and is judged by nonmedical means, that is in conjunction with his job description, policy disability clause conditions and personal factors, such as education, experience etc.

For case of reference we have provided the definitions as accepted by the insurance market of impairment and disability and would request that you do not comment on the nature of the occupational disability unless of the policy definition have been made available to you and such decision specifically requested. As this decision may interfere with your doctor – patient relationship it is your own interests not to make such comments.

We require an objective medical opinion of the impairment experienced by your patient, providing full details of all limitations in movement, use or restriction.

The details of all treatment from the elementary to the most advanced will provide us with full picture of the condition and its progression.

Thank you for your assistance in this claim.

DECLARATION

Name___________________________________Qualifications_________________________

Practice No____________________________

Date (DDMMYY)___________________________Signature______________________________

Postal Address____

Postal code____

Telephone Number______________________________