MEDICAL CERTIFICATE (Permanent or Temporary Disability claim)

Completed and signed documents should be returned to:
claims@ukheshe.co.za
or contact (010) 444 0040 for assistance

To be completed by Attending Medical Practitioner.

Dear Doctor

This medical information requested in this report is in support of a policy benefit payable for the life insured. Your expertise and advice will provide a vital link in the process of assessing the claim. Please ensure you have confirmed the identity of the person in respect of whom this information is provided (using photographic form of identity)
As this report is in support of a claim application, any cost in connection with this report will be for the account of the life insured in terms of the policy, unless otherwise specified by uKheshe Payment Solutions and confirmed in writing.
We thank you for your co-operation.

Section A: Medical Practitioner details

Full names and surname_____

Address: _____

_____

E-mail address: _____

Cell phone number: _____

Business telephone: number: _____

Practice number: _____

HPCSA registration number: _____

Qualification: _____

Section B: Insured Person details

Policy number: _____

Full names: _____

Surname: _____

ID number: _____

Name of hospital/clinic: _____

Hospital/Clinic file number: _____

Section C: Medical history

Are you the claimant's regular doctor? Yes: _____ No: _____

- If not, please provide the name and telephone number of the doctor who referred this patient to you:

_____

Please give the details of any practitioners, specialists or hospitals to which the life insured has been referred. Please include copies of all available specialist reports and any investigations performed.

Name of Doctor	Contact Details of Doctor	Name of Facility (e.g. Hospital name)	Consultation Date	Treatment Details	Date of last visit to doctor

Has the Insured ever been tested for HIV antibodies? YES_____ NO_____ Date:_____

Result _____ (PLEASE ATTACH RESULTS) Did the

insured use tobacco in any form? YES_____ NO_____

If so, how much_____

Did the insured consume alcohol on a weekly basis? YES_____ NO_____

If yes, how many units per week? _____

Did you ever advise the insured to reduce their alcohol consumption? YES_____ NO_____

Section D: Details of Insured Person's Impairment

(Please tick relevant block, supply reports where indicated and answer questions in the spaces provided.):

Loss of, or loss of use of:	
Both hands (at or above the wrist)	
Both feet (at or above the ankle joint)	
One hand (at or above the wrist)	
One foot (at or above the ankle joint)	
One hand AND one foot (at or above the wrist or ankle joint)	
Please provide the following as relevant: *Amputation* *Sketches indicating the level of amputation* *Loss of Use of Body Part* *Clinical findings indicating range of movement of the joints, power, sensation, ankylosis (with position), neurological Impairment, including radiographic and electroconduction study results, where appropriate.* *Paraplegia and Quadriplegia* *Diagnosis and clinical findings including range of movement, power and sensation (after full rehabilitation has been completed)*	
Both eyes (permanent and irreversible loss of all vision with no light perception in both eyes)	
Please provide:	
Vision acuity pre- and post-correction	
Visual field where applicable	
Speech (permanent and irreversible loss of the ability to speak as a result of injury or disease to the vocal cords or brain)	
Please provide: *Copies of specialist reports confirming the diagnosis of a loss of the ability to speak.*	
3rd degree burns (>40% of body surface)	
3rd degree burns (20-40% of body surface)	
Please provide copies of specialist reports confirming that the Life Covered has suffered third degree burns. *Indicate the areas of third degree burn wounds in a sketch:*	

What is the immediate cause of physical impairment? _____

Date of accident or commencement of illness (if know): _____

Date the insured first became aware of the symptoms (if illness): _____

Was the Insured suffering from this condition when you were first consulted? YES_____ NO_____

Please provide full details of past and present treatment including medication, rehabilitation, etc.

_____

_____

_____

How has the patient's condition responded to treatment?

_____

Is the patient's current impairment permanent and irreversible? What is the prognosis for recovery?

_____

_____

State fully if any of the following contributed or predisposed to the cause of physical impairment:

Previous Illness/injury: _____

_____

Habits: _____

_____

Declaration by Medical Practitioner

I hereby declare that I have personally examined and attended to the life insured and that the contents of this report are true and correct.

Full names and surname_____

Doctor's signature_____

Date and Stamp _____