

# Disability Claim

**Please return Claim Forms to:**  
1. **Fax to**  
(011) 351-3003  
2. **Post Originals to:**  
Life Claims  
P O Box 87428  
HOUGHTON 2041



## TO BE COMPLETED BY THE MEDICAL ATTENDANT

### DETAILS OF INSURED

Policy Number .....  
Name of Patient .....  
Date of Birth (DDMMYY) ..... I.D. number.....  
Address .....  
Occupation .....  
Employer .....  
Employer's telephone number (.....).....

### KINDLY PROVIDE US WITH THE FOLLOWING INFORMATION

1. Diagnosis of patient's condition  
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2. The cause of the patient's disability  
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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

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

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

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8. Details of any hospitalisations or special investigations

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

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10. Details of any specialised treatment

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

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

For ease 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 the details of the policy definition have been made available to you and such a decision specifically requested. As this decision may interfere with your doctor-patient relationship it is in 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 a 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 (.....).....