PPS DISABILITY CLAIM FORM-MEMBER

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This form applies to PPS Professional Provider™ Disability Insurance (DISA), PPS Professional Disability Provider™ (PDP), PPS Business Life Provider™ with Disability Insurance (DISA), PPS Life Assurance with Accelerated Disability, Business Disability Provider benefits and Education Cover.

REQUIREMENTS

Claims in respect of the disability benefit should be submitted with the following supporting documents:

- PPS Disability claim form - Doctor fully completed by the treating doctor of the insured for the illness.
- PPS Disability Disability Claim form - Member fully completed.
- Any other medical reports regarding the medical condition.
- All relevant medical, blood and special investigation reports, plus any other relevant documentation confirming/supporting the illness.

Information:

To enable the timely assessment of the claim all required details should be completed in full.

Omission of any information will delay the finalisation of the claim. Additional information (at PPS's cost) may be requested from either the claimant or any Medical Practitioner. The claimant and/or Medical Practitioner will be notified if additional information is required.

PART A: MEMBER DETAILS

Member Number: | | | | | | | | | | National ID Number: | | | | | | | | | | | | | |

Surname: | | | | | | | | | | | | | | | | | | | | | | | | | Initials: | | |

Email: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Cellular: | | | | | | | | | | | |

PART B: MEDICAL CONDITION

1. Please state the medical condition for which you are claiming:

2. Provide brief details of the chronological history (date of onset and progression up to now) of the condition; if this claim is due to an injury/accident, describe the nature of the accident, and include police case number/s where applicable:

3. Did the illness or injury originate outside a South African Development Country (SADC)? Yes ☐ No ☐

If, **YES**, specify in which country: _____

PART C: OCCUPATIONAL DETAILS PRIOR TO INCAPACITY

1. Were you employed: Full time: ☐ Part-time: ☐ Private Practice: ☐

2. If employed either "full time" or "part time", please provide the following information:

2.1 Name of Institution/Company: _____

2.2 Position held: _____

2.3 Employment start date: _____ End date: _____

2.4 Reason for termination of employment:

3. Have you been medically boarded? Yes ☐ No ☐

Date boarded: _____

Name and contact details of person(s) in charge of the boarding process:

4 Please give a complete and accurate description of the exact duties and nature of your full-time occupation, prior to incapacity or enclose a copy of your job description.

5. Please provide a percentage indication of time spent engaged in:

To be completed by self-employed and salaried applicants.										
Driving as an integral part of your professional duties	Walking on even terrain	Walking on uneven terrain	Climbing ladders, stairs, scaffoldings, etc.	Bending knees / Squatting/ Stooping,etc.	Use of both hands as an integral part of your professional duties (excluding typing and administration)	Fine coordination (e.g. dentistry, surgery, etc.)	Sitting including for administrative purposes	Lifting objects >20kg	Other (Please specify)	**Total**
%	%	%	%	%	%	%	%	%	%	**100%**

PART D: CURRENT OCCUPATION DETAILS

1.1. Are you still engaged in any part of your main occupation/ involved in your business/practice? Yes ☐ No ☐

1.2. If Yes, please give a complete and accurate description of the exact duties and nature of your full-time occupation or enclose a copy of your job description:

Please select your current working status and indicate the number of hours worked per day:

		Tick	Hours worked per day
1	Not working		
2	Full time in own occupation		
3	Full time in similar occupation		
4	Full time in unrelated occupation		
5	Part time in own occupation		
6	Part time in similar occupation		
7	Part time in unrelated occupation		

1.3 If self- employed:

a) Is your surgery/rooms/administrative offices: Still open ☐ Closed ☐

Date closed: _____

b). Is your business being conducted on your behalf? Yes ☐ No ☐

If yes, kindly provide details of the responsible person(s) (the name and contact details):

2. How do you occupy your day (without professional activities)?

3. What discomfort/ difficulty do you still experience which prevents you from practicing your professional duties at the same capacity as prior to your illness/injury illness?

4. What adaptations do you require in order to carry out your occupational duties at the same capacity as prior to your illness/injury?

Adaptations mean any alterations or adjustments to work environment (e.g. small adjustment to your working hours and workload or adjustments to your work area), which makes carrying out your occupational duties easier or possible.

5. Describe the occupational activities that you are **able** to carry out **now** even if you are not currently working or have retired:

6. Provide details regarding your: Gross Professional Income: Currently: R _____

Before illness/disability: R _____

7. When do you hope to return to a meaningful, supportive, income-generating employment?

PART E: TREATMENT DETAILS

1. Please list the medical doctor/s and all allied medical practitioners (physiotherapist or occupational therapist) involved in your treatment?

Surname and Initials	Phone number	Email Address	Speciality	Date last consulted

2. Indicate (tick) how regularly you consult the doctor/specialist in charge of your treatment:

Weekly	
Bi weekly	
Monthly	
Three monthly	
Other Specify:	

3. Please indicate what other treatment or therapy you have received for your disability/sickness:

	Once	Twice	Thrice	Date of last treatment
Surgery				
Therapy e.g. physiotherapy				
Radiotherapy				
Chemotherapy				
Counselling				
Other				

4a. Are you currently on any medication? Y ☐ N ☐

4b. Please list the medication, dose and frequency:

Name of medication	Dose	Frequency

4c. Are you experiencing any side effects from this medication? Y ☐ N ☐

If yes, provide comprehensive details:

5. Has your doctor suggested any other form of treatment (surgery, occupational therapy, return to work program)? Y ☐ N ☐

If yes, what treatment has the doctor suggested and when will this treatment commence:

Kindly provide the name and contact details of the doctor/therapist who is responsible for the above:

If no, please provide reasons:

PART F: QUALITY OF LIFE DETAILS

NOTE: Rate questions (1 – 8) on a scale from 1-10. (1) being normal to (10) being severely affected.
If your rating is 4 or greater, please explain how it has impacted the specific area in the space provided.

1. Your usual routine daily activities e.g. bathing, dressing. (scale from 1-10) ☐

2. Were you able to drive a motor vehicle before your impairment? Y ☐ N ☐

   If so, to what extent does your sickness/disability impede this function now? (scale from 1-10) ☐

3. Prior to your incapacity, did you do any shopping, household chores or maintenance? Y ☐ N ☐

   If so, kindly provide details as to your current involvement in these activities. (scale from 1-10) ☐

4. Are you suffering from any pain? Y ☐ N ☐

   If so, please rate the severity of the pain that you are suffering. (scale from 1-10) ☐

5. Do you sleep well? Y ☐ N ☐

   If no, please rate the deterioration of your normal sleep pattern. (scale from 1-10) ☐

6.1 Indicate to what degree your ability to concentrate has been negatively affected. (Scale from 1-10) ☐

6.2 Indicate to what degree your memory has been negatively affected. (Scale from 1-10) ☐

7. Have you experienced any loss of self-confidence or self-esteem due to your impairment? Y ☐ N ☐

Please rate the extent to which you are affected (scale from 1-10) ☐

8. Before your incapacity, did you socialise with family/ friends/ colleagues? Y ☐ N ☐

Please rate the extent to which your social life has been negatively affected by your incapacity (scale from 1-10) ☐

9. Please explain how your house has been adapted to accommodate your condition/disability. E.g. (any railings, ramps etc.):

10. Please indicate your level (e.g. seldom, often, frequent) of participation in these non-professional activities:

	Before Incapacity	After Incapacity
Tennis		
Squash		
Golf		
Hiking		
Walking		
Jogging		
Gardening		
Reading		
Visiting		
Socialising		
Other		

11a. Are you registered with a statutory body? Y ☐ N ☐

11b. If yes, please indicate your registration number _____

11c If not registered, provide the date deregistered _____ and reason/s _____

12. Do you handle your own personal finances? Y ☐ N ☐

If your answer is No, please give reasons _____

13. What do you consider as your two (2) most disabling symptoms?

14. What emotional/ psychological effects are you experiencing as a result of your impairments?

15. Have you submitted a claim for disability benefits with another company for this same condition/illness. Y ☐ N ☐

If yes, please provide the name of the company: _____

Contact person name and surname: _____

Contact details: _____

PART G: BANKING DETAILS FOR CLAIM BENEFIT VIA EFT

NOTE: Only complete when payment is to be made into a bank account other than from which premiums are collected:
(Please attach a cancelled cheque or bank statement stamped by the bank.)

Name of account holder:

Name of bank:

Account number:

Branch code:

Branch:

Type of account: Current ☐ Savings ☐ Cheque ☐ Transmission ☐

Indemnity – Please take note that PPS will not be held liable for incorrect payments, if the information received is incorrect

PART H: DECLARATION

I specifically authorise PPS Insurance to communicate any requirements to my financial advisor which may entail providinginformation regarding my current medical condition Y ☐ N ☐

Financial Advisor's Name:

Financial Advisor's Email:

I certify that all the above information is true and correct and I/we authorise PPS Insurance to:

a) Access any information which it deems necessary to assess any insurance risk or to consider a claim and I/we understand that if I/we choose not to provide this information PPS will not be able to assess the claim for insurance.
b) Share with other insurers and their representation body any information in the possession of PPS Insurance, either directly or through a database operated by, or for insurers as a group and authorise PPS to also collect required personal information from other insurers as exchange of information helps to waive costs and combat fraud.
c) Disclose any information to the PPS Holdings Trust, subsidiaries, affiliates, Profmed or other persons provided that it is necessary to properly underwrite, manage or service the policy, policy assets or myself. PPS Insurance may be required to disclose your information to regulatory or government agencies.
d) Obtain credit information from any person or institution.

AND

I/we understand that I can request details of the information held by my insurer and request its correction where appropriate.

AND

I/we authorise a doctor, hospital, medical aid or any other person to provide this information to PPS.
PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS will adhere to any laws governing the protection of (and access to) personal information; and will not use your information for any purpose not provided for in your Policy Contract and in this Part H.

Signature of policyholder: _____

Signed at _____ this _____ day of _____ 20 _____

Did you require assistance when completing this form? Y ☐ N ☐

If yes, please provide details of the person that assisted you:

Name of person: _____ Signature: _____

Relationship: _____

PART I: GENERAL

Contact Details:

Claims department:

Email: claims@pps.co.za

Fax: (011) 644 4520

Queries:

Email: claims@pps.co.za

Telephone: (011) 644 4320