PPS OCCUPATIONAL OR FUNCTIONAL DISABILITY OR SEVERE ILLNESS CLAIM FORM - MEMBER

Note: The PPS Occupational or Functional Disability or Severe Illness -Member claim form will be used to assess benefits under the Occupational Disability, Functional Disability, Synchronized Disability or Severe Illness benefit respectively.

Please specify the benefit which you are claiming for:

Functional Disability Benefit/Provider ☐

Occupational Disability Benefit/Provider with or without OSRB ☐

Severe Illness Benefit ☐

REQUIREMENTS

In addition to the information listed below, claims should be submitted with the following supporting documents:

- PPS Occupational or Functional Disability or Severe Illness claim form, fully completed by the appropriate specialist.
- Detailed medical attendant report. A guideline for the details required is provided for easy reference on the doctor's claim form.
- All relevant medical, blood and special investigation reports, plus any other relevant documentation confirming/supporting the illness.
- All medical information will be treated confidentially, according to the ASISA guidelines on management of Medical Information.
- Reports are to be supplied at the policyholder's own cost.
- Please refer to the list of claim definitions which also explains the different severity levels, in your latest Policy Summary and Appendix A and F of your Provider Policy wording, for additional information on the benefit.
- Submit claim forms and questionnaires to: claims@pps.co.za or fax to 011 644 4520.

PART A: MEMBER DETAILS

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

Name: | | | | | | | | | | | | | | | | | | | | | | | | | | |

Surname: | | | | | | | | | | | | | | | | | | | | | | | | | | |

Cell No: 0 | | | | | | | | | | Tel No. (w): 0 | | | | | | | | | |

Email address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Home address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

PART B: CLAIM DETAILS

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

1.1 Date of diagnosis: D D / M M / Y Y Y Y Date of onset of symptoms: D D / M M / Y Y Y Y

Date of first consultation: D D / M M / Y Y Y Y

2. Provide brief details of the chronological history (from date of onset and progression up to now) of the condition

3. Did the sickness/disability originate outside of South Africa? YES ☐ NO ☐

If yes, specify in which country: _____

PART C: EMPLOYMENT QUESTIONS RELATED TO THE WORK PERFORMED DIRECTLY PRIOR TO THE ONSET OF THE SICKNESS/DISABILITY AND CURRENTLY

1. Please list all your qualifications:

Qualification	Year obtained

1.1 Are you registered with a statutory body? Yes ☐ No ☐

1.2 If yes, please indicate your registration number: _____

1.3 If not registered, provide the date of deregistration _____

and reason/s: _____

2. Please state the following:

	Prior to onset of sickness/disability	Currently
Profession		
Job title		
Full time, part time or private practice (select one that applies)		
Were/Are you working: in own occupation, similar occupation or unrelated occupation (select one that applies)		
Name of institution/company		
Employment start date		
Employment end date		
Number of hours worked per day		

3. List the occupational duties/tasks you were able to perform **prior to onset of sickness/disability** as well as any other duties/tasks you are **currently performing with the sickness/disability.** Allocate % of time spent and indicate the interdependence of your tasks/ duties:

Prior to onset of sickness/disability			**Currently**		
Duty/Task	%Time spent	Interdependence	Duty /Task	%Time Spent	Interdependence
e.g. Surgery	60%	Consultation with patients	e.g. Surgery	10%	Consultation with patients
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		
6.			6.		
7.			7.		
8.			8.		

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

If yes, please state the date you were boarded _____

and name and contact details of person in charge of the boarding process:

5. Please state whether your surgery/rooms or administrative offices are currently: still open: ☐ closed: ☐

5.1 Date closed: D D / M M / Y Y Y Y

5.2 If still open, provide details of who is running your surgery/rooms or administrative offices?

Name:

Contact details: 0

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

7. What discomfort/ difficulty do you currently experience which prevents you from practicing your professional duties at the same capacity as prior to your sickness/disability?

8. 8.1. List the accommodations or adaptations that have been implemented or explored (since the onset of the sickness/disability), to enable you to carry out all or some of your occupational duties, at the same capacity as prior to your sickness/disability.

Note: 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:

8.2 Kindly indicate which of these adaptations have not been feasible and provide a reason thereof.

8.3 Contact details (name and phone number), of person/s at work that can be contacted about the accommodations made at work:

PART D: QUALITY OF LIFE DETAILS

Rate to what extent your sickness/disability has affected the following areas in your life:

Note: Rate the questions on a scale from 1-10 (1) being no changes to (10) being severe. If your rating is 4 or greater, please explain how it has impacted the specific area in the space provided.

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

2. Were you able to drive a motor vehicle before your impairment? Yes ☐ No ☐

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

3. When do you suffer from pain? (e.g. end of day, night time etc.)

4. Describe your sleeping pattern:

5. Comment on the impact that your sickness/disability has on the following functions:

Function	Impact due to sickness/disability
Concentration	
Memory	
Self-confidence/Self-esteem	
Ability to socialise	

6. Has there been adaptations/adjustments to your home? If so, please give details: e.g. (any railing, ramps etc.):

7. Please indicate your level (e.g. seldom, often, frequent) of participation in non-professional activities, such as tennis, golf, gardening, etc.:

Detail of activity	Before Sickness/Disability *(seldom/often frequent)*	Currently *(seldom/often/frequent)*

8. Do you handle your own personal finances? Yes ☐ No ☐

If your answer is no, please give reasons _____

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

10. Have you submitted a claim for disability benefits with another company for this same sickness /disability? Yes ☐ No ☐

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

Contact person name and surname: _____

Contact details: _____

PART E: PAYMENT OF BENEFIT

Should you wish the benefit to be paid into a bank account **other than that from which premiums are collected**, please complete the details provided on **Annexure A attached.**

PART F: DECLARATION

I specifically authorize PPS Insurance to communicate with my financial advisor regarding current claim. Yes ☐ No ☐

Financial Advisor's Name:

Email:

I authorise PPS Insurance to:

a) Access any information, which it deems necessary to assess any insurance risk or to consider a claim and I understand that if I choose not to provide this information PPS Insurance will not be able to assess my claim.

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 Insurance to also collect my personal information from other insurers as exchange of information helps to save costs and combat fraud.

c) Disclose any information to the PPS Holdings Trust, subsidiaries, affiliates or other persons provided, that it is necessary to properly underwrite, manage or service the policy, policy assets or myself.

d) Disclose my information to regulatory or government agencies where required by law.

e) Obtain credit information from any person or institution.

AND

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

AND

I authorise a doctor, hospital, medical aid or any other person to provide this information to PPS Insurance. PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS Insurance 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.

Signature of policyholder:

Signed at on this day of 20

Annexure A

BANKING DETAILS

Should you wish the benefit to be paid into a bank account **other than that from which premiums are collected,** please complete the details below and provide PPS Insurance with a proof of account. The accepted proof of account must be either a cancelled cheque or a bank-stamped letter on the bank's letterhead. PPS Insurance cannot accept responsibility for incorrect payment of benefits where this information has not been completed correctly.

Name of account holder:

Account type:

Account number:

Name of bank:

Branch name:

Branch code:

Bank's Physical address: (**)

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

(**): Required for International payments