MEDICAL REPORTS FOR DEATHS

Estate Late:

National ID number/ Passport if no ID:

IMPORTANT

- This certificate is required in addition to the Registrar's Certificate of Death.
  The Medical Practitioner should send it to PPS Insurance at ppsdeathclaims@pps.co.za or fax 011 644 4520
- PPS Insurance agrees to pay an internal agreed rate. These details are available from executor/beneficiary.
  In order for payment to be processed, we require an invoice of account.

PART A: DETAILS OF MEDICAL PRACTITIONER

I, the undersigned (please print)

HPCSA Reg No.: A registered medical practitioner,

Home Business Postal address:

Postal Code:

Cellular: 0 Tel Home/Business: 0

Email:

National ID number /Passport if no ID:

certify that the following facts are true and correct in respect of the death of the late (full name):

1. General

(a) Were you the deceased's family doctor? YES NO

If yes, since what date? D D / M M / Y Y Y Y

(b) If not, please supply the name and address of the deceased's family doctor:

2. Details of death

(a) Date of death: D D / M M / Y Y Y Y

(b) Cause of death:

ICD 10 Code:

(c) Contributory Cause (if any):

ICD 10 Code:

(d) Dates of first and subsequent consultations in respect of the disease that caused the death:

(e) Was the deceased informed of this diagnosis? YES NO

(i) If so, when was the condition first diagnosed: D D / M M / Y Y Y Y

(ii) Please provide the name and contact details of the medical practitioner that diagnosed the condition, if not diagnosed by you:

(f) State the nature of treatment from onset of the illness up to the date of death:

(g) Was an inquest held? YES ☐ NO ☐

If yes, state if it was a Private or Judicial Inquest?

3. Other diseases or complaints that the deceased consulted you about: Nature of Illness or complaint Treatment

Nature of Illness or complaint	Treatment	Date of first and subsequent consultations

4. Consultations with other medical practitioners including specialists of which you are aware?

Name	Address	Phone	Fax

5. Habits:

In your opinion did the deceased ever suffer from one of the following? Provide details to those questions answered yes.

(a) Depression / anxiety YES ☐ NO ☐

(b) Alcohol abuse YES ☐ NO ☐

(c) Drug abuse YES ☐ NO ☐

(d) Did the deceased receive any treatment or therapy for any of the above? If so, please provide details. YES ☐ NO ☐

6. Additional Information:

(a) Is there any reason to believe that the deceased's death is in any way due to or that it arose directly or indirectly, entirely or partially from AIDS or HIV infection? If yes, please give details: YES ☐ NO ☐

(b) Was the deceased ever tested for HIV? If yes, please give details, including date of diagnosis. YES ☐ NO ☐

MEDICAL PRACTITIONER'S DETAILS

HPCSA Reg No: Practice No:

Surname: Initials:

Telephone No: Fax No:

Email Address:

Address:

Signed at this day of 20

Signature of Medical Attendant