FAMILY RESPONSIBILITY RIDER BENEFIT - ADMISSION (DECLARATION BY DOCTOR)

The Professional Provident Society Holdings Trust No. IT 312/2011 (PPS Holdings Trust) is a Registered South African Trust.
The Professional Provident Society Insurance Company Limited
Reg. No. 2001/017730/06 ("PPS Insurance") is an Authorised Financial Services Provider - Licence No. 1044

NOTE *To be completed by the treating Medical Attendant only.*

Please answer all the questions in full to ensure a timeous and complete assessment of your client's claim.

PPS obtained prior written consent from the life insured in terms whereof additional information pertaining to the claim may be provided.
PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your patient's personal information.
PPS will adhere to any laws governing the protection of (and access to) personal information; and will not use the information for any purpose not provided for in the PPS Policy Contract.

Please return the fully completed form to PPS Claims Fax: 011 644 4520 or email to claims@pps.co.za

PART A: MEMBER DETAILS

Member number:

Initials: Surname:

Date of birth: D D / M M / Y Y Y Y

Email:

Cellular: 0

PART B: DETAILS OF THE CLAIM

Particulars of the patient

Name:

Surname:

National ID number/Passport if no ID:

PART C: MEDICAL CONDITION

1. Primary diagnosis: ICD 10 code:
2. Secondary diagnosis (if applicable): ICD 10 code:
3. Did the condition have: an acute onset? Slowly progressive onset?
4. Provide **date of initial consultation** and brief details of the **chronological history** of the condition, or sequence of events:
5. Does the patient have any pre-disposing risk factors e.g. raised cholesterol, hypertension, alcohol abuse, prior injuries, chronic disease/injury/illness which may have led to the development of the illness or claim event? Please provide details:
6. Treatment or investigations conducted for the above risk factors:
   NOTE Please attach copies of all relevant investigations conducted.

Date	Details	Doctor

PART D: MEDICAL PRACTITIONER'S DETAILS

HPCSA Reg No: | | | | | | | | | | | |

Practice No: | | | | | | | | | | | |

Surname: ____________________ Initials: | | | | | |

Telephone No: | | | | | | | | | | | |

Fax No: | | | | | | | | | | | | | |

Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Address: ____________________

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Signed at ____________ this ________ day of ____________ 20 ________

Signature of Medical Attendant ____________________