CLAIM FOR SICKNESS BENEFIT- DECLARATION BY MEMBER FOR CLAIM RELATED TO COVID-19 (CORONAVIRUS) EXPOSURE OR INFECTION

IMPORTANT PPS Insurance aims to pay all valid claims timeously. Please read the PPS Claims Protocol for COVID-19 before completing this form.

PART A: MEMBER DETAILS

PPS Member number: Date of birth: D D / M M / Y Y Y Y

Surname: Initials:

E-mail address:

Cellular: 0

Medical Aid details:

PART B: PARTICULARS OF CLAIM

Details of symptom/s, that you experience/d:

Have you experienced, or are you currently, experiencing symptoms? Yes ☐ No ☐

Date of onset of symptom/s: D D / M M / Y Y Y Y

Date symptom/s ended: D D / M M / Y Y Y Y

Select symptoms that you experience/d:

Fever (>38^{0}C)		Chills		Cough		Sore throat	
Vomiting		Diarrhea		Body pains		Shortness of breath	

Other (please specify if applicable):

Have you been hospitalised with severe acute respiratory illness AND there is no alternative diagnosis that explains the clinical presentation? (attach evidence of hospitalisation) Yes ☐ No ☐

Date of admission: D D / M M / Y Y Y Y

Date of discharge: D D / M M / Y Y Y Y

Testing for COVID-19:

Have you been tested for COVID-19?Yes ☐ No ☐

Date/s of sample collection

If tested Positive, date of first Positive test result; D D / M M / Y Y Y Y

If tested Negative,

Date of first Negative test result; D D / M M / Y Y Y Y ;

Date of Second Negative test result; D D / M M / Y Y Y Y

Exposure to a Probable or Confirmed case of COVID19:

Question	**Yes**	**No**	**Unknown**
Were you in close contact with a **confirmed** case of COVID-19?			
If yes, provide details of the confirmed COVID-19 case (i.e. name, surname, ID number and contact number and any supporting evidence).			

Question	**Yes**	**No**	**Unknown**
Were you in close contact with a **probable** case of COVID-19?			
If yes, provide details of the probable COVID-19 case (i.e. name, surname, ID number and contact number and any supporting evidence).			

Question	**Yes**	**No**	**Unknown**
Do you have a history of travel outside of South Africa?			
If yes, provide details (countries visited and dates of travel).			

Question	Yes	No
Did the illness originate outside a Southern African Development Community country (SADC)	☐	☐
If, YES state which country:		

Question	Yes	No	Unknown
Do you, or have you worked in or attended a health care facility where patients with COVID-19 infections were being treated	☐	☐	☐
If yes, provide details (name of facility, reason for attendance, dates).			

Information regarding isolation or quarantine:

Were you advised to isolate or quarantine? Yes ☐ No ☐

Who advised you to isolate or quarantine?

Important: Attach a **copy of the instruction** to isolate or quarantine.

Self	☐	Employer	☐	Government Authority	☐
NICD	☐	Medical Practitioner	☐	Other (specify)	☐

Contact person:

Contact number: 0

E-mail address:

Date of start of isolation or quarantine: D D / M M / Y Y Y Y

Date end of isolation or quarantine: D D / M M / Y Y Y Y

Claim dates: (sickness period and isolation or quarantine period)

TOTAL BENEFITS:

I was **NOT** able to perform **ANY** professional duties:

From: D D / M M / Y Y Y Y To: D D / M M / Y Y Y Y

PARTIAL BENEFITS:

I was able to perform some of my work duties e.g. critical administrative tasks while recuperating at home; or worked for a limited period per day.

From: D D / M M / Y Y Y Y To: D D / M M / Y Y Y Y

PART C: EMPLOYMENT QUESTIONS RELATED TO THE WORK PERFORMED DIRECTLY PRIOR TO CLAIM.

Occupation:

Commencement date of occupation: D D / M M / Y Y Y Y

1. ONLY COMPLETE if Self-employed

State the name of your practice/business:

Gross Professional Income (Annual income from professional fees and nett income from trading activities; including all overhead expenses):

(Minus) Actual Expenses (Expenses incurred in the running of the business that are not remunerated to the professional. Expenses that will terminate if the business is sold or closed):

(Equals) Personal Income (Gross Professional Income minus Actual Expenses):

2. ONLY COMPLETE if in Salaried employment

State the name of your employer:

State your annual income as:

Annual Total Cost to Company
(Annual salary plus all fringe benefits):

(Plus) Performance Bonus (Average over the last 3 years):

(Equals) Total Gross (Professional income):

PART D: BANKING DETAILS FOR SICKNESS 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:

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

PART E: DECLARATION

I specifically authorise PPS Insurance to communicate any requirements to my financial advisor which may entail providing information regarding my current medical condition ☐ YES ☐ NO

Financial Advisor's Name:

Financial Advisor's 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 will not be able to assess my 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 my personal information from other insurers as exchange of information helps to wave costs and combat fraud.PPS can further process any such information in accordance or compatible with the purpose for which it was collected.

c) Disclose any information to the PPS Holdings Trust, subsidiaries, affiliates, Profmed or other persons provided that it is necessary to properly underwrite, manage, assess the claim 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 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.

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 E.

Signed at (Place): on this day of 20

Signature of member: