PREGNANCY RELATED SICKNESS BENEFIT CLAIM (DECLARATION BY TREATING OBSTETRICIAN/ GYNAECOLOGIST)

The Professional Provident Society Holdings Trust No IT 312/2011 (PPS) is a Registered South African Trust
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Dear Doctor,

We appreciate your time and cooperation to assist us in considering a Sick Pay benefit claim for your patient.

The following is important:

- PPS has signed consent from your patient to obtain confidential medical information from you.
- Please attach **all** relevant investigations conducted.
- Please attach **all** ultrasonography, cardiotocography reports and blood tests that were performed to confirm the diagnosis.
- Any costs to provide this information will be for your patient's account.
- **Please send the form and supporting documents to**:
  - **Fax: 011 644 4520 or**
  - **E-mail: claims@pps.co.za**

- Your prompt response will be appreciated.

PART A: MEMBER DETAILS

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

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

PART B: GENERAL CLAIM INFORMATION

1. What was the gestational age at time of the complication?

2. What is the estimated date of delivery (expected prior to complication)? D D / M M / Y Y Y Y

3. Please provide the primary obstetric diagnosis

4. Date of diagnosis: D D / M M / Y Y Y Y Date of onset of symptoms: D D / M M / Y Y Y Y

5. Date of first consultation: D D / M M / Y Y Y Y ICD10 code(s):

6. Please provide brief details of the chronological history of the condition, or sequence of events:

7. Details of treatment administered for current illness, or claim event including medication, bedrest, physiotherapy and psychotherapy,etc:

Name of medication/therapy	Doses and frequency of treatment	Date commenced	Completion date

8. Provide brief details of any surgical procedure performed for current illness or claim event. Please include any complications of surgery that have occurred

9. Were there any predisposing factors for this condition?

PART C: CLAIM DETAILS

1. TOTAL BENEFITS: The patient was unable to perform ANY professional duties from:

Start date: D D / M M / Y Y Y Y End date: D D / M M / Y Y Y Y

NOTE To qualify for Total benefits your patient should not be able to perform any of the occupational duties normally associated with their above occupation, whether physical or mental tasks, including minor physical tasks such as consulting, or administrative tasks such as dealing with queries.

2. PARTIAL BENEFITS: The patient was able to perform SOME Professional duties from:

Start date: D D / M M / Y Y Y Y End date: D D / M M / Y Y Y Y

NOTE To qualify for Partial benefits your patient is able to carry out some of their normal occupational duties as above, or work reduced working hours compared to normal working hours, but not all. PPS Claims will also assess this in line with the occupation and profession.

3. When did your patient resume her usual professional duties on a full- time basis? D D / M M / Y Y Y Y

4. If your patient has not returned to work, please indicate the expected return to work date:

Full time: D D / M M / Y Y Y Y Part time: D D / M M / Y Y Y Y

PART D: TREATING OBSTETRICIAN'S/GYNAECOLOGIST'S DETAILS

HPCSA Reg No: Practice No:

Surname: Initials:

Telephone No: 0 Fax No: 0

Email address:

Physical Address:

Signed at: this day of 20

Signature of Obstetrician/Gynaecologist: