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

IMPORTANT

1. All medical information will be treated according to the ASISA guidelines on Confidentiality of Medical Information. Any costs incurred in obtaining the supporting document/s will be for the life Insured's account.
2. **PPS Claims Contact details:**
   e-mail: claims@pps.co.za
   Fax: 011 644 4520
   Queries
   e-mail: memberservices@pps.co.za
   Tel: 011 644 4300

COVID-19 Related Sick Leave Claim Requirements		
Topic		**Requirements and notes**
A	**All types of COVID claims**	• Copy of COVID test result • Declaration by Member Claim Form • Declaration by Doctor Claim Form PPS Insurance aims to pay all valid claims timeously. Accurately completed forms facilitate the assessment process and allows for a correct assessment. Please read the **PPS Claims Protocol for COVID-19 available on the PPS website** (pps.co.za/covid-19-coronavirus), before completing this form.
B	**Claim duration**	
1	**10 days or less**	As noted in **A** above Most people who contract COVID-19 are asymptomatic or have mild symptoms that will not prevent them from working remotely. This is especially evident once vaccinated. Some people however suffer moderate to severe symptoms that prevent them from performing some or all of their usual professional duties. People who contract COVID-19 generally recover sufficiently to resume work duties within 10 days.
2	**Exceeding 10 days**	• **In addition to A above, a medical report** that include copies of all relevant medical, blood and special investigations undertaken • Any other relevant documentation **to justify the need for extended recovery**. Refer to the **addendum attached to the Declaration by Doctor Claim form for a set of specific requirements** to substantiate extended claims.
C	**COVID complications**	• A **detailed breakdown of the complications and a medical report** that include copies of all relevant medical, blood and special investigations undertaken. • Any other relevant documentation, **to confirm the complications and substantiate the need for extended recovery.** Refer to the **addendum attached to the Declaration by Doctor Claim form for a set of specific requirements** to substantiate extended claims.
D	**Long COVID**	• Beyond the initial period of infection, claims should be submitted to PPS monthly • Claim forms should be signed and submitted after the period claimed for, as claims cannot be assessed prospectively.

PART A: MEMBER DETAILS

Member number: | | | | | | | | | Date of birth D D M M Y Y Y Y

Surname: Initials:

National ID number : Cellular:

Medical aid name: Medical aid number:

Email address :

PART B: PARTICULARS OF CLAIM

1.1 Provide **details of the disease/condition** that **significantly prevented you** from performing your **usual professional duties** and **required optimal medical treatment or supervision** such as: medication, hospitalisation, surgery or rehabilitation.

1.2 Date of onset of disease/condition: D D M M Y Y Y Y

1.3 Describe the **symptoms of the disease/condition** and **how it affected** your **ability to perform** your usual **professional duties**:

1.4 Date symptom/s of the disease/condition ended: D D M M Y Y Y Y

1.5 Testing for COVID-19:

Have you been tested for COVID-19? YES ☐ NO ☐

Date or sample collection	Type of test e.g. PCR or Antibody test, rapid antigen test	Result	Result Date

1.6 Describe the **complications experienced** and **how it influenced** your **ability to** perform your **professional duties (where applicable)**.

2. Did the illness originate outside a Southern African Development Community country (SADC)? YES ☐ NO ☐

If YES, specify country: _____

3. Details of hospitalisation and rehabilitation

3.1 **Hospitalisation**

Did you require admission to hospital? YES ☐ NO ☐

Name of hospital:

Attach a copy of the admission sheet or the hospital account showing admission and discharge dates if you were hospitalised for at least four consecutive days and wish to claim against your Admission Rider Benefit (if applicable).

3.2 **Rehabilitation**

Studies have shown that **early intervention** with rehabilitation, e.g. physiotherapy, occupational therapy, counselling or biokinetics has **yielded positive results.**

Describe the measure/management you and your specialist have undertaken/ are undertaking to improve your symptoms:

Date rehabilitation commenced: D D M M Y Y Y Y

rehabilitation stopped: D D M M Y Y Y Y

If rehabilitation was stopped, kindly provide reasons:

4. Please state the name(s) of the doctor(s) and allied medical practitioners who attended to you, in respect of this claim. It may be necessary for our claims area to contact them for further information.

Practitioner's Surname and Initials	**Consultation Date/s**	**Tel**	**E-mail**

5. Claim dates:

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 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

DATE OF RETURN TO WORK:

On a Partial basis D D M M Y Y Y Y On a Full-time basis: D D M M Y Y Y Y

Provide **details of the duties** that you were **able to perform remotely**, focusing on the nature of the duties performed and time spend performing these duties, e.g. administrative work, virtual consultations, etc.:

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

6. Please state the following regarding your occupation:

a) Current Occupation:

b) Commencement date of occupation: D D M M Y Y Y Y

c)

Question	YES	NO
Are you a healthcare worker?		
Are you self-employed?		
Are you able to work remotely?		

d) Describe the nature of your usual professional duties:

7. 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):

(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):

8. 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: ☐