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. The Professional Provident Society Insurance Company Limited Reg. No 2001/017730/06 Professional Provident Society Insurance Company Limited is a licensed insurer conducting life insurance business, a licensed controlling company and an authorised financial services provider. Any reference to PPS in this form means PPS Insurance.



Dear Doctor,

We appreciate your time and cooperation in assisting PPS to assess your patient's claim accurately.

Kindly provide comprehensive answers to the questions listed below and attach copies of all relevant investigations available to you.

PPS obtained prior written consent from the life insured in terms of which medical information pertaining to the claim may be provided. In terms of the Promotion of Access to Information Act 2 of 2000 (POPIA), and other applicable legislation, PPS may also be obliged to release such medical information obtained as part of the claims assessment process to the policyholder at their request. Furthermore, PPS may be legally obliged to share the medical information with a third party in accordance with the laws of the Republic of South Africa, including but not limited to POPIA.

By providing the medical information, you hereby consent to the sharing and further processing thereof. PPS undertakes that it will share and process such medical information in accordance with the purpose for which it was collected, which may include instances of complaints or dispute resolution. However, the utmost care will be taken to prevent any unreasonable or unlawful disclosure.

Please send the fully completed form and supporting documentation to PPS Claims at claims@pps.co.za

PART A: MEMBER DETAILS				
Member number:				
Surname:				
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)?				
3. Please provide the primary obstetric diagnosis:				
4. Date of diagnosis: / / / Date of onset of symptoms: / / / /				
5. Date of first consultation:				
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, 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 the current illness or claim event. Please include surgical complications 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: / / End Date: / /					
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: / <th <="" th=""> / <th <="" th=""> <th <="" th=""> <th <="" th=""> <th <="" t<="" th=""></th></th></th></th></th>	/ / <th <="" th=""> <th <="" th=""> <th <="" th=""> <th <="" t<="" th=""></th></th></th></th>	<th <="" th=""> <th <="" th=""> <th <="" t<="" th=""></th></th></th>	<th <="" th=""> <th <="" t<="" th=""></th></th>	<th <="" t<="" th=""></th>	
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?					
4. If your patient has not returned to work, please indicate the expected return-to-work date:					
Full time: /					
PART D: TREATING OBSTETRICIAN'S/GYNAECOLOGIST'S DETAILS					
HPCSA reg no:					
Surname:					
E-mail:					
Address:					
Signed at: this day of 20					
Signature of obstetrician/gynaecologist:					