FAMILY RESPONSIBILITY RIDER BENEFIT – DEATH CLAIM (DECLARATION BY DOCTOR)

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 claims@pps.co.za.

PART A: MEMBER DETAILS

Member number:

Initials: Surname:

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

E-mail:

Cell phone:

PART B: DETAILS OF THE CLAIM

Particulars of the patient

Name:

Surname:

ID/Passport number (if no ID):

PART C: MEDICAL CONDITION

1. Cause of death:
2. Contributory causes of death (if applicable):
3. Date of death: D D M M Y Y Y Y
4. Provide **date of initial consultation** and brief details of the **chronological history** of the condition or sequence of events resulting in the death.

5. Treatment or investigations conducted in respect of cause of death and contributory cause(s) of death:

NOTE Please attach copies of all relevant investigations conducted.

Date	Details	Doctor

PART D: MEDICAL PRACTITIONER'S DETAILS

HPCSA reg no.: Practice no.:

Initials: Surname:

Telephone:

E-mail:

Address:

Postal code:

Signed at this day of 20

Signature of medical attendant

DISCLAIMER:

By submitting this form electronically, you acknowledge that your electronic signature holds the same legal weight as a handwritten signature. For authorised electronic signature details, contact your financial adviser or e-mail memberservices@pps.co.za. Using unauthorised electronic signatures is at your own risk and PPS Insurance disclaims liability for any related issues.