PPS BUSINESS LIFE COVER BENEFIT
ACCIDENTAL DEATH BENEFIT DECLARATION BY DOCTOR

The Professional Provident Society (PPS) Holdings Trust No IT 312/2011 is a registered South African Trust. The Professional Provident Society Insurance Company Limited Reg. No 2001/017730/06 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 (PAIA) 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 the Protection of Personal Information Act 2013 (POPIA).

You hereby consent to the sharing and further processing of the medical information. 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 ppsdeathclaims@pps.co.za

PPS contact details:

Claim submissions:
E: ppsdeathclaims@pps.co.za

Claim-related enquiries:
E: memberservices@pps.co.za
T: 0860 123 777 or +27 (0)10 085 3820
Monday to Friday from 07:00 to 19:00 and Saturday from 08:00 to 13:00

IMPORTANT

- This certificate is required in addition to the Registrar's Certificate of Death.
- The medical practitioner should complete this form.
- PPS Insurance agrees to pay an internal agreed rate. These details are available from the executor/beneficiary.
- For payment to be processed, we require a completed electronic fund transfers (EFT) form.
- Payment will be made on receipt of an invoice reflecting the practice banking details and the life-insured's name and identification number.

MEDICAL REPORT FOR DEATH

I, the undersigned registered medical practitioner, _____

ID/Passport number (if no ID): _____

certify that the following facts are true and correct in respect of the death of the late (full name and surname):

_____

1. General

(a) Were you the deceased's family doctor? YES ☐ NO ☐

If YES, since what date? D D M M Y Y Y Y

(b) If NO, please supply the name and address of the deceased family doctor:

_____

2. Details of death

(a) Date of death: D D M M Y Y Y Y

(b) Cause of death: _____

(c) ICD-10 code: _____

(d) Contributory cause (if any): _____

(e) ICD-10 code: | | | | | | | | | | |

(f) Dates of first and subsequent consultations in respect of the disease that caused the death:

(g) Was the deceased informed of this diagnosis? YES ☐ NO ☐

(i) If YES, when was the condition first diagnosed? D D M M Y Y Y Y

(ii) Please provide the name and contact details of the medical practitioner that diagnosed the condition, if not diagnosed by you:

(h) State the nature of treatment from the onset of the illness up to the date of death:

(i) Was an inquest held? YES ☐ NO ☐

If YES, state if it was a private or judicial inquest.

3. Other diseases or complaints that the deceased consulted you about including the nature of the illness or complaint and treatment

Nature of Illness or complaint	**Treatment**	**Date of first and subsequent consultations**

4. Consultations with other medical practitioners including specialists of which you are aware:

Name	**E-mail**	**Phone**

5. Habits:

In your opinion, did the deceased ever suffer from any of the following? Provide details to those questions answered YES.

(a) Mental/behavioural disorders YES ☐ NO ☐

(b) Alcohol abuse YES ☐ NO ☐

(c) Drug abuse YES ☐ NO ☐

(d) Did the deceased receive any treatment or therapy for any of the above? If YES, please provide details. YES ☐ NO ☐

MEDICAL PRACTITIONER DETAILS

HPCSA reg no: Practice no:

Surname: Initials:

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 PPS-accredited 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.