BUSINESS TERMINAL ILLNESS 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 claims@pps.co.za

PARTICULARS OF LIFE-INSURED

Surname:

Initials:

ID/Passport number (if no ID):

MEDICAL ILLNESS

1. Primary Diagnosis and ICD-10 code (compulsory field)

Date of diagnosis: D D M M Y Y Y Y

Date of onset of symptoms: D D M M Y Y Y Y

Date of first consultation: D D M M Y Y Y Y

2. Secondary, contributory or concurrent medical condition:

3. Provide date of **initial consultation** and brief details of the **chronological history** of the illness or sequence of events:

4. List the investigations that were performed to confirm the diagnosis and attach copies of all the test results:

Date	Details

5. Is there further treatment available for this illness? Provide details where applicable:

6. What is your patient's life expectancy (in months), based on your medical findings?

MEDICAL PRACTITIONER DETAILS

HPCSA reg no: Practice no:

Initials: Surname:

Telephone:

E-mail:

Signed at this day of 20

Signature of medical doctor:

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.