PPS PROFESSIONAL HEALTH PRESERVER - 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, a comprehensive medical report 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 PPS Claims at claims@pps.co.za

PARTICULARS OF LIFE-INSURED

Member number: | | | | | | | | | |

ID/Passport number (if no ID): | | | | | | | | | | | | | |

Surname: | | | | | | | | | | | | | | | | | | | | |

Initials: | | | | |

DETAILS OF CLAIM

Please note the assessment of this claim may depend on the severity of your patient's condition.

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

1.1 Indicate the staging if applicable, e.g., AJCC, FIGO.

2. Secondary, contributory or concurrent medical conditions:

3. Name of current and previous medical practitioners who have treated your patient for this condition:

Doctor's name	Contact details and e-mail address	Speciality	Date of initial consultation	Date of last consultation

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.