PPS PROFESSIONAL HEALTH PRESERVER/ PPS BUSINESS HEALTH PROVIDER™ / SEVERE ILLNESS BENEFIT CLAIM FORM - MEMBER

The Professional Provident Society Holdings Trust No. IT 312/2011 (PPS Holdings Trust) is a Registered South African Trust
Professional Provident Society Insurance Company Limited Reg. No. 2001/017730/06 ("PPS Insurance")
PPS Insurance is an Authorised Financial Services Provider - Licence No. 1044

LIFE ASSURED DETAILS

The relevant definitions for these benefits are contained in your Policy Document should you wish to refer to them.

Member number:_____ ID number: _____

Name:_____ Surname: _____

Physical address: _____

Telephone number (h):_____Email: _____

Telephone number (w):_____Cellphone: _____

MEDICAL CONDITION

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

Diagnosis: _____

Date of diagnosis:_____Date of onset of symptoms: _____

Date of first consultation: _____

Name of current and previous medical practitioners who have treated you for this condition:

Doctor's name	Address and contact details	Speciality	Date of last consultation

Is there further treatment for this condition? Please give details: _____

_____

_____

In order to assess this claim timeously, full and comprehensive reports regarding the medical condition are required. This will include all relevant medical, blood and special investigations reports, PLUS any other relevant documentation. All medical information will be treated according to the ASISA guidelines on Confidentiality of Medical Information. Reports are to be supplied at the member's own cost.

Important: please submit these reports to: claims@pps.co.za or fax to 011 644 4520.

BANKING DETAILS

When payment of the claim is to be paid into a bank account other than from which premiums are collected, please complete the details below and provide PPS with a proof of account. The accepted proof of account is either a cancelled cheque or a bank-stamped letter on the bank's letterhead.

Name of Account Holder: _____

Name of Bank:_____Account No: _____

Branch Name:_____Branch Code: _____

Type of Account: ☐ Current ☐ Savings ☐ Cheque ☐ Transmission

Indemnity – Please take note that PPS will not be held liable for incorrect payments, if the information received is incorrect.

DECLARATION

I specifically authorise PPS Insurance to communicate any requirements to my financial advisor which may entail providing information regarding my current medical condition. Y N

Financial Advisor's Name: _____

Financial Advisor's Email: _____

I authorise PPS Insurance To:

a) Access any information which it deems necessary to assess any insurance risk or to consider a claim and I understand that if I choose not to provide this information PPS will not be able to assess my claim for insurance.
b) Share with other insurers and their representation body any information in the possession of PPS Insurance, either directly or through a database operated by, or for insurers as a group and authorise PPS to also collect my personal information from other insurers as exchange of information helps to save costs and combat fraud.
c) Disclose any information to the PPS Holdings Trust, subsidiaries, affiliates, Profmed or other persons provided, that it is necessary to properly underwrite, manage or service the policy, policy assets or myself. PPS Insurance may be required to disclose your information to regulatory or government agencies.
d) Obtain credit information from any person or institution.

AND

I understand that I can request details of the information held by my insurer and request its correction where appropriate.

AND

I authorise a doctor, hospital, medical aid or any other person to provide this information to PPS.

PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS will adhere to any laws governing the protection of (and access to) personal information; and will not use your information for any purpose not provided for in your Policy Contract and in this declaration.

Signature of life assured:_____ Date: _____

Signature of policyholder:_____ Date: _____