PPS BUSINESS LIFE COVER BENEFIT
ACCIDENTAL DEATH BENEFIT DECLARATION BY DOCTOR

Dear Doctor,

We appreciate your time and cooperation to assist us in considering a Business life cover claim.

Please send the completed form and any supporting documents/ test results to:
ppsdeathclaims@pps.co.za or fax; 011 644 4520

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 (please print)

HPCSA Reg No:

A registered medical practitioner, Practice number:

Tel Business:

Postal code:

Email:

Certify that the following facts are true and correct in respect of the death of the late (Full name, surname and ID number):

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 not, 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) ICD10 code:

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

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

(i) If so, 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:

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

(g) Was an inquest held? YES ☐ NO ☐

If yes, state if it was a Private or Judicial inquest?

3. Details of other diseases or health ailments that the deceased consulted you for:

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	Address	Phone	Fax

5. Habits:

In your opinion did the deceased ever suffer from any of the following? Provide details to those questions answered yes (Dates, treatment, etc.).

(a) Depression/anxiety YES ☐ NO ☐

(b) Alcohol abuse YES ☐ NO ☐

(b) Drug abuse YES ☐ NO ☐

6. Additional information:

(a) Please provide any predisposing factors which contributed to the death.

Signature of Medical Attendant

Signed at _____ on this _____ day of _____ 20 _____