

BUSINESS DISABILITY BENEFIT (OSRB; OWN AND SIMILAR OCCUPATION) - MEMBER



The Professional Provident Society Holdings Trust No IT 312/2011(PPS Holding 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

CLAIM REQUIREMENTS

Please select the Business Solution for which you are claiming and provide the policy number:

SOLUTION	Buy-and-sell	Key Person Insurance	Contingent Liability Plan	Credit Loan Account Cover
POLICY NUMBER				

Claims in respect of the PPS Business Disability benefit should be submitted with the following supporting documents:

- Member claim form.
- Claim form completed by the treating Medical Doctor.
- Detailed medical report and copies of all investigations performed to confirm diagnosis
- The Business Assurance Policyholder claim form.
- Submit the completed forms to claims@pps.co.za or fax to 100 644 4520

PART A: PARTICULARS OF LIFE INSURED

Surname: Initials:

National ID number: Cellular: 0

Medical aid name:

Medical aid number:

Email address:

PART B: MEDICAL CONDITION

1. Please state the medical condition for which you are claiming:

2. Provide brief details of the chronological history (date of onset and progression up to now) of the condition; if this claim is due to an injury/accident, describe the nature of the accident, and include police case number/s where applicable:

3. Did the illness or injury originate outside a South African Development Country (SADC)? YES NO

If YES, specify in which country: _____

PART C: OCCUPATIONAL DETAILS PRIOR TO INCAPACITY

1. Were you employed: Full time: Part-time: Private practice:

2. If employed either "full time" or "part-time", please provide the following information:

2.1 Name of Institution/Company: _____

2.2 Position held: _____

2.3 Employment start date: _____ End date: _____

2.4 Reason for termination of employment:

3. Have you been medically boarded? YES NO

Date boarded:

Name and contact details of person(s) in charge of the boarding process:

4. Please give a complete and accurate description of the exact duties and nature of your full-time occupation, prior to incapacity or enclose a copy of your job description.

5. Please provide a percentage indication of time spent engaged in:

To be completed by self-employed and salaried applicants.										
Driving as an integral part of your professional duties.	walking on even terrain.	Walking on uneven terrain	Climbing ladders, stairs, scaffolding, etc	Bending knees/squatting/stooping etc.	Use of both hands as an integral part of your professional duties (excluding typing and administration)	Fine coordination (e.g. dentistry, surgery, etc)	Sitting including for administrative purpose.	Lifting objects >20kg	other (please specify)	Total
%	%	%	%	%	%	%	%	%	%	100%

PART D: CURRENT OCCUPATIONAL DETAILS

1.1 Are you still engaged in any part of your main occupation/involved in your business/practice? YES NO

1.2 If yes, please give a complete and accurate description of the exact duties and nature of your full-time occupation or enclose a copy of your job description:

Please select your current working status and indicate the number of hours worked per pay:

		Tick	Hours worked per day
1	Not working		
2	Full time in own occupation		
3	Full time in similar occupation		
4	Full time in unrelated occupation		
5	Part time in own occupation		
6	Part time in similar occupation		
7	Part time in unrelated occupation		

1.3 If self-employed:

a) Is your surgery/rooms/administrative offices: Still open Closed

Date closed: _____

b) Is your business being conducted on your behalf? YES NO

If yes, kindly provide details of the responsible person(s) (the name and contact details):

2. How do you occupy your day (without professional activities)?

3. What discomfort/difficulty do you still experience which prevents you from practicing your occupational duties at the same capacity as prior to your illness/injury?

4. What *adaptations do you require in order to carry out your occupational duties at the same capacity as prior to your illness/injury?

**Adaptations mean any alterations or adjustments to work environment (e.g. adjustment to your working hours and workload or adjustments to your work area), which makes carrying out your occupational duties easier or possible.*

5. Describe the occupational activities that you are able to carry out now even if you are not currently working or have retired:

6. Provide details regarding your: Gross Professional Income: Currently: R_____

Before illness/disability: R _____

7. When do you hope to return to a meaningful, supportive, income-generating employment?

PART E: TREATMENT DETAILS

1. Please list the medical doctor/s and all allied medical practitioners (physiotherapist or occupational therapist) involved in your treatment?

Surname and Initials	Phone number	Email address	Speciality	Date last consulted

2. Indicate (tick) how regularly you consult the doctor/specialist in charge of your treatment:

Weekly	<input type="checkbox"/>
Bi weekly	<input type="checkbox"/>
Monthly	<input type="checkbox"/>
Three monthly	<input type="checkbox"/>
Other: Specify:	<input type="checkbox"/>

3. Please indicate what other treatment or therapy you have received for your disability/sickness:

	Once	Twice	Thrice	Date of last treatment
Surgery				
Therapy e.g. physiotherapy				
Radiotherapy				
Chemotherapy				
Counselling				
Other				

4a. Are you currently on any medication? YES NO

4b. Please list the medication, dose and frequency:

Name of medication	Dose	Frequency

4c. Are you experiencing any side effects from this medication?

If yes, provide comprehensive details:

5. Has your doctor suggested any other form of treatment (surgery, occupational therapy, return to work program)? YES NO

If yes, what treatment has the doctor suggested and when will this treatment commence:

Kindly provide the name and contact details of the doctor/therapist who is responsible for the above:

If no, please provide reasons:

PART F: QUALITY OF LIFE DETAILS

NOTE: Rate questions (1-8) on a scale from 1-10. (1) being normal to (10) being severely affected.

If your rating is 4 or greater, please explain how it has impacted the specific area in the space provided.

1. Your usual routine daily activities e.g. bathing, dressing. (scale from 1-10)

2. Were you able to drive a motor vehicle before your impairment? YES NO

If so, to what extent does your sickness/disability impede this function now? (scale from 1-10)

3. Prior to your incapacity, did you do any shopping, household chores or maintenance? YES NO

If so, kindly provide details as to your current involvement in these activities. (scale from 1-10)

4. Are you suffering from any pain? YES NO

If so, please rate the severity of the pain that you are suffering. (scale from 1-10)

5. Do you sleep well? Yes NO

If no, please rate the deterioration of your normal sleep pattern. (scale from 1-10)

6.1 Indicate to what degree your ability to concentrate has been negatively affected. (Scale from 1-10)

6.2 Indicate to what degree your memory has been negatively affected. (Scale from 1-10)

7. Have you experienced any loss of self-confidence or self-esteem due to your impairment? YES NO

8. Before your incapacity, did you socialise with family/friends/colleagues? YES NO

Please rate the extent to which your social life has been negatively affected by your incapacity (scale from 1-10)

9. Please explain how your house has been adapted to accommodate your condition/disability. E.g. (any railings. Ramps etc.):

10. Please indicate your level (e.g. seldom, often, frequent) of participation in these non-professional activities:

	Before Incapacity	After Incapacity
Tennis		
Squash		
Golf		
Hiking		
Walking		
Jogging		
Gardening		
Reading		
Visiting		
Socialising		
Other		

11a. Are you registered with a statutory body? YES NO

11b. If yes, please indicate your registration number _____

11c. If not registered, provide the date deregistered _____ and reason/s _____

12. Do you handle your own personal finances? YES NO

If your answer is No, please give reasons _____

13. What do you consider as your two (2) most disabling symptoms?

14. What emotional/psychological effects are you experiencing as a result of your impairments?

15. Have you submitted a claim for disability benefits with another company for this same condition/illness. YES NO

If yes, please provide the name of the company: _____

Contact person name and surname: _____

Contact details: _____

PART G: DECLARATION

I specifically authorise PPS Insurance to communicate any requirements to my/our financial advisor which may entail providing information regarding my current medical condition YES NO

Financial Advisor's Name:

Financial Advisor's Email:

I certify that all the above information is true and correct and 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 the 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 required personal information from other insurers as exchange of information helps to waive 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.

Signature of Life Insured:

Signed at this day of 20

PART I: GENERAL

Contact Details:

Claims department:

Email: claims@pps.co.za

Fax: (011) 644 4520

Queries:

Email: claims@pps.co.za

Telephone: (011) 644 4320