CLAIM FOR SICKNESS BENEFIT-DECLARATION BY MEMBER

FOR CLAIM RELATED TO COVID-19 (CORONAVIRUS) INFECTION

Professional Provident Society Holdings Trust No IT 312/2011 (PPS) is a Registered South African Trust. The Professional Provident Society Insurance Company Limited Reg. No 2001/017730/06. Professional Provident Society Insurance Company Limited 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.

IMPORTANT

1. All medical information will be treated according to the Association for savings and investment South Africa (ASISA) guidelines on Confidentiality of Medical Information.
   Any costs incurred in obtaining the supporting document(s) will be for the life insured's account.

2. PPS Claims Contact details:

   Claim submissions:
   E: claims@pps.co.za
   Claim-related enquiries:
   E: memberservices@pps.co.za
   T: 0860 123 777 or +27 (0) 11 644 4300
   Monday to Friday from 07:00 to 19:00
   and Saturday from 08:00 to 13:00

COVID-19-related sick leave claim requirements		
Topic		**Requirements and notes**
A	**All types of COVID-19 claims**	• Copy of COVID-19 test result • Declaration by Member Claim form • Declaration by Doctor Claim form PPS Insurance aims to pay all valid claims timeously. Accurately completed forms facilitate the assessment process and allows for a correct assessment.
B	**Claim duration**	
1	**Ten days or less**	As noted in **A** above Most people who contract COVID-19 are asymptomatic or have mild symptoms that will not prevent them from working remotely. This is especially evident once vaccinated. Some people, however, suffer moderate to severe symptoms that prevent them from performing some or all of their usual professional duties. People who contract COVID-19 generally recover sufficiently to resume work duties within ten days.
2	**Exceeding ten days**	• **In addition to A above, a medical report** that includes copies of all relevant medical, blood and special investigations undertaken. • Any other relevant documentation **to justify the need for extended recovery.** Refer to the **addendum attached to the Declaration by Doctor form for a set of specific requirements** to substantiate extended claims.
C	**COVID-19 complications**	• **A detailed breakdown of the complications and a medical report** that include copies of all relevant medical, blood and special investigations undertaken. • Any other relevant documentation **to confirm the complications and substantiate the need for extended recovery.** Refer to the addendum attached to the Declaration by Doctor form for a set of specific requirements to substantiate extended claims.
D	**Long COVID-19**	• Beyond the initial period of infection, claims should be submitted to PPS monthly. • Claim forms should be signed and submitted after the period claimed for, as claims cannot be assessed prospectively.

PART A: MEMBER DETAILS

Member number:

Surname: Initials:

Medical aid name: Medical aid number:

E-mail address: Cellular:

PART B: PARTICULARS OF CLAIM

1.1 Provide **details of the disease/condition** that **significantly prevented** you from performing your **usual professional duties** and **required optimal medical treatment or supervision** such as: medication, hospitalisation, surgery or rehabilitation.

1.2 Date of onset of disease/condition: / /

1.3 Describe the **symptom(s) of the disease/condition** and **how it affected** your **ability to perform** your usual **professional duties:**

1.4 Date symptom(s) of the disease/condition ended: / /

1.5 Testing for COVID-19

Have you been tested for COVID-19? YES NO

Date or sample collection	**Type of test e.g., PCR or antibody antigen test**	**Result**	**Result date**

1.6 Describe the **complications experienced** and **how it influenced** your **ability to** perform your **professional duties (where applicable):**

2. Did the illness originate outside a Southern African Development Community (SADC) country? YES ☐ NO ☐

If YES, specify country: _____

3. Details of hospitalisation and rehabilitation

3.1 Hospitalisation

Did you require admission to hospital? YES ☐ NO ☐

Name of hospital:

Attach a copy of the admission sheet or the hospital account showing admission and discharge dates if you were hospitalised for at least four consecutive days and wish to claim against your Admission Rider benefit (if applicable).

3.2 Rehabilitation

Studies have shown that **early intervention** with rehabilitation, e.g., physiotherapy, occupational therapy, counselling or biokinetics has **yielded positive results.**

Describe the measure/management you and your specialist have undertaken/are undertaking to improve your symptoms:

Date rehabilitation commenced: ☐☐ / ☐☐ / ☐☐☐☐

Date rehabilitation stopped: ☐☐ / ☐☐ / ☐☐☐☐

If rehabilitation was stopped, kindly provide reasons:

4. Please state the name(s) of the doctor(s) and allied medical practitioner(s) who attended to you, in respect of this claim. It may be necessary for our claims area to contact them for further information.

Practitioner's initials and surname	**Consultation date(s)**	**Tel**	**E-mail**

5. Claim dates

TOTAL BENEFITS

I was **NOT** able to perform **ANY** professional duties:

From: ☐☐ / ☐☐ / ☐☐☐☐ To: ☐☐ / ☐☐ / ☐☐☐☐

PARTIAL BENEFITS

I was able to perform **some** of my work duties while recuperating at home or worked for a limited period per day.

From: ☐☐ / ☐☐ / ☐☐☐☐ To: ☐☐ / ☐☐ / ☐☐☐☐

DATE OF RETURN TO WORK:

On a partial basis: ☐☐ / ☐☐ / ☐☐☐☐ On a full-time basis: ☐☐ / ☐☐ / ☐☐☐☐

Provide **details of the duties** that you were **able to perform remotely,** focusing on the nature of the duties performed and time spend performing them e.g., administrative work, virtual consultations, etc.:

PART C: EMPLOYMENT QUESTIONS RELATED TO THE WORK PERFORMED DIRECTLY PRIOR TO CLAIM

6. Please state the following regarding your occupation:

a) Current occupation:

b) Commencement date of occupation: ☐☐ / ☐☐ / ☐☐☐☐

c) **Tick the option(s) applicable to you:**

i. Are you a healthcare worker? YES ☐ NO ☐

ii. Are you self-employed? YES ☐ NO ☐

iii. Are you able to work remotely? YES ☐ NO ☐

d) Describe the nature of your usual professional duties:

7. ONLY COMPLETE if self-employed:

State the name of your practice/business:

Gross professional income

(Annual income from professional fees and nett income from trading activities): ☐☐☐☐☐☐☐☐☐☐

(Minus) Actual expenses

(Expenses incurred in the running of the business that are not remunerated to the professional. Expenses that will terminate if the business is sold or closed): ☐☐☐☐☐☐☐☐☐☐

(Equals) Personal income

(Gross professional income minus actual expenses): ☐☐☐☐☐☐☐☐☐☐

8. ONLY COMPLETE if in salaried employment

State the name of your employer:

State your annual income as:

Annual total cost to company
(Annual salary plus all fringe benefits): ☐☐☐☐☐☐☐☐☐☐

(Plus) Performance bonus (Average over the last three years): ☐☐☐☐☐☐☐☐☐☐

(Equals) Total gross (Professional income): ☐☐☐☐☐☐☐☐☐☐

PART D: BANKING DETAILS FOR SICKNESS BENEFIT PAYMENT VIA EFT

NOTE: Financial governance requires that all benefits regarding Sickness claims must be settled to the same account from which your premiums are paid **(premium-paying account).** Please note that this is an improved security measure to mitigate financial risks for claiming policyholders.

Please provide alternative bank details below if you cannot receive payment to your premium-paying account for any reason.

Changing the account to which claim benefits are paid will require additional diligence and proof.

The required additional diligence will take an additional five working days before payment can be made.

If you must change your banking details, please include the required proof together with this claim form.

I understand this note and request PPS to: *(Select the appropriate option)*

1. Pay any benefits due to my existing premium-paying account:
2. Use the new account details below to pay any benefits due to me:

2.1. Please update my premium-paying account to the new details below for future premium payments: YES ☐ NO ☐

Name of account holder:	
Name of bank:	
Account number:	
Branch code:	
Type of account:	

If you have selected option 2 above, please provide PPS with proof of account and certified proof of the account holder's identity. The accepted proof of account is a bank-stamped verification letter on the bank's letterhead not older than three months. PPS cannot make changes to this account without the required proof.

Foreign bank accounts: *Please note that in terms of the PPS Provider™ Policy, premiums from the policyholder should be paid from a South African bank account and benefits to the policyholder should also be paid into a South African bank account, in South African currency. Accordingly, PPS Insurance assumes no responsibility or liability whatsoever in the event the policyholder pays premiums from a foreign bank account, or the policyholder nominates a foreign bank account for receipt of policy benefits. Furthermore, any payment to and from PPS Insurance involving a foreign bank shall be at the sole discretion of PPS Insurance and subject to the South African foreign exchange regulations and other relevant legislation as amended from time to time. PPS Insurance assumes no responsibility or liability to inform the policyholder of any changes in such regulations and legislation.*

Indemnity: Please note that PPS will not be held liable for incorrect payments if the account information supplied is incorrect. By signing this form, the policyholder indemnifies PPS and holds PPS harmless against any losses, liabilities, claims, charges, expenses, costs or any other actions or demands of whatever nature, which could or might be suffered or incurred by the policyholder or any third party whether directly or indirectly, caused by and/or arising out of the payment into the above account.

PART E: AUTHORISATION TO COMMUNICATE WITH FINANCIAL ADVISER

I specifically authorise PPS Insurance to communicate any requirements to my financial adviser which may entail providing information regarding my current medical condition. YES ☐ NO ☐

Financial adviser's name:

Financial adviser's e-mail:

PART F: DECLARATION

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I _____(member full name and surname) and ID number:_____,

authorise PPS Insurance to:

a) Access any information deemed necessary to assess any insurance risk or to consider a claim. I understand that if I choose not to provide this information, PPS Insurance will not be able to assess the claim for insurance.

b) Share with other insurers and their representative 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 Insurance to also collect required personal information from other insurers as exchange of information helps to waive costs and combat fraud. PPS can further process any such information in accordance or compatible with the purpose for which it was collected.

c) Disclose any information to the PPS Holdings Trust, PPS Insurance's subsidiaries and affiliates or other persons provided that it is necessary to properly underwrite, manage assess the claim or service the policy, policy assets or myself. PPS Insurance may be required to disclose my 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 Insurance. PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS Insurance 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 Part F.

Signature of policyholder: _____

Signed at: _____ this _____ day of _____ 20 ____