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Certificate of Medical Attendant (in support of terminal illness claim)

To be completed by the Medical Attendant (Treating Specialist)

Dear Doctor

This medical information requested in this report is in support of a policy benefit payable for the life insured. Your
expertise and advice will provide a vital link in the process of assessing the claim.

As this report is in support of a claim application, any cost in connection with this report will be for the account of
the life insured in terms of the policy, unless otherwise specified by Rand Mutual Life and confirmed in writing.

We thank you for your co-operation.

Section A: Medical Practitioner details

Full names and surname_____

Address: _____

_____

_____

E-mail address:_____

Cell phone number: _____

Business telephone: number:_____

Practice number:_____

HPCSA registration number:_____

Qualification:_____

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Section B: Life insured details

Policy number:_____

Full names:_____

Surname:_____

ID number:_____

Name of hospital/clinic:_____

Hospital/Clinic file number:_____

Section C: Medical references

Please give the details of any practitioners, specialists or hospitals to which the life insured has been referred. Please include copies of all available specialist reports and any investigations performed.

Name of Doctor	Contact Details of Doctor	Name of Facility (e.g. Hospital name)	Consultation Date	Treatment Details	Date of last visit to doctor

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Section D: Medical history

Please give a full medical history, including the following:

Diagnosis:_____

Stage of the condition/illness:_____

When was the condition initially diagnosed: _____
(Please provide us copies of the test results that confirm the initial diagnosis as well as the current severity)

Which doctor made the initial diagnosis:_____

Date of your first consultation with the life insured:_____

Date of your last consultation with the life insured: _____

Anticipated prognosis:_____

Is the condition referred to above likely to lead to the life insured's death within the next 12 months:
_____

Please complete the table below in respect of the life assured's background medical history:

Consultation Date	Clinical presentation/ symptoms	Diagnosis	Treatment prescribed	Specialist referral or for further investigation	Compliance with treatment

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Has the Insured ever been tested for HIV antibodies? YES____ NO____ Date:_____

Result_____ (PLEASE ATTACH RESULTS)

Did the insured use tobacco in any form? YES____NO___

If so, how much_____

Did the insured consume alcohol on a weekly basis? YES___NO_____

If yes, how many units per week? _____

Did you ever advise the insured to reduce their alcohol consumption? YES_____NO___

Declaration by Medical Practitioner

I hereby declare that I have personally examined and attended to the life insured and that the contents of this report are true and correct.

Full names and surname_____

Doctor's signature_____

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Date and Stamp _____