Certificate of Medical Attendant (in support of death claim)

FAX COMPLETED & SIGNED DOCUMENTS TO 086 639 3867
OR EMAIL TO claims@simply.co.za
OR POST TO P.O. BOX 1800, UMHLANGA ROCKS, 4320

To be completed by the Personal Medical Attendant (Usual Doctor)

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 Simply 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: _____

Section B: Life insured details

Policy number: _____

Full names: _____

Surname: _____

ID number: _____

Name of hospital/clinic: _____

The underwriter of this policy is Old Mutual Alternative Risk Transfer Limited (OMART), a registered Long-Term Insurer.

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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

Section D: Medical history

Please give a full medical history, including the following:

Date of your first consultation with the life insured: _____

Date of your first consultation with regard to the medical condition which contributed to the death: _____

Date of your last consultation with the life insured: _____

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Please complete the table below:

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

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_____

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Section E: Cause of Death

Was an inquest or post mortem inquiry held? YES_____ NO_____

What is the immediate cause of death? _____

Date of commencement of illness: _____

Date the insured first became aware of the symptoms: _____

Was the Insured suffering from this condition when you were first consulted? YES_____ NO_____

State fully if any of the following contributed or predisposed to the cause of death:

Previous Illness/injury: _____

_____

Habits: _____

_____

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_____

Date and Stamp _____