

**Medical Report**  
**(in support of Physical Impairment claim)**



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

**To be completed by Attending Medical Practitioner.**

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. Please ensure you have confirmed the identity of the person in respect of whom this information is provided (using photographic form of identity)

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: Insured Person details**

Policy number: \_\_\_\_\_

Full names: \_\_\_\_\_

Surname: \_\_\_\_\_

ID number: \_\_\_\_\_

Name of hospital/clinic: \_\_\_\_\_



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Hospital/Clinic file number: \_\_\_\_\_

**Section C: Medical history**

Are you the claimant's regular doctor? Yes: \_\_\_\_\_ No: \_\_\_\_\_

- If not, please provide the name and telephone number of the doctor who referred this patient to you:

\_\_\_\_\_

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

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 \_\_\_\_\_



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

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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 \_\_\_\_\_

**Section D: Details of Insured Person's Impairment**

(Please tick relevant block, supply reports where indicated and answer questions in the spaces provided.):

<b>Loss of, or loss of use of:</b>	
<b>Both hands</b> (at or above the wrist)	
<b>Both feet</b> (at or above the ankle joint)	
<b>One hand</b> (at or above the wrist)	
<b>One foot</b> (at or above the ankle joint)	
<b>One hand AND one foot</b> (at or above the wrist or ankle joint)	
<b>Please provide the following as relevant:</b>	
<u>Amputation</u>	
Sketches indicating the level of amputation	
<u>Loss of Use of Body Part</u>	
Clinical findings indicating range of movement of the joints, power, sensation, ankylosis (with position), neurological Impairment, including radiographic and electroconduction study results, where appropriate.	
<u>Paraplegia and Quadriplegia</u>	
Diagnosis and clinical findings including range of movement, power and sensation (after full rehabilitation has been completed)	
<b>Both eyes</b> (permanent and irreversible loss of all vision with no light perception in both eyes)	
<b>Please provide:</b>	
Vision acuity pre- and post-correction	
Visual field where applicable	
<b>Speech</b> (permanent and irreversible loss of the ability to speak as a result of injury or disease to the vocal cords or brain)	
<b>Please provide:</b>	
Copies of specialist reports confirming the diagnosis of a loss of the ability to speak.	
<b>3<sup>rd</sup> degree burns</b> (>40% of body surface)	
<b>3<sup>rd</sup> degree burns</b> (20-40% of body surface)	
Please provide copies of specialist reports confirming that the Life Covered has suffered third degree burns.	



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*Indicate the areas of third degree burn wounds in a sketch.*

What is the immediate cause of physical impairment? \_\_\_\_\_

Date of accident or commencement of illness (if know): \_\_\_\_\_

Date the insured first became aware of the symptoms (if illness): \_\_\_\_\_

Was the Insured suffering from this condition when you were first consulted? YES \_\_\_\_\_ NO \_\_\_\_\_

Please provide full details of past and present treatment including medication, rehabilitation, etc. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How has the patient's condition responded to treatment? \_\_\_\_\_

Is the patient's current impairment permanent and irreversible? What is the prognosis for recovery? \_\_\_\_\_

\_\_\_\_\_

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

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 \_\_\_\_\_



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Date and Stamp \_\_\_\_\_



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