

**Certificate of Medical Attendant  
(in support of death claim)**



EMAIL COMPLETED & SIGNED DOCUMENTS TO: claims@simply.co.za  
OR POST TO: Simply Financial Services  
3rd Floor, Grove Exchange  
9 Grove Avenue, Claremont, 7945

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: \_\_\_\_\_



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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.

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

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

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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 \_\_\_\_\_

