Certificate of Medical Attendant
(in support of terminal illness 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 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 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: ____

Hospital/Clinic file number: ____

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Simply is a registered financial services provider (FSP 47146)

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

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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:

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)

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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____

Date and Stamp ____

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