Certificate of medical attendant

Occupational Disability

Email completed & signed documents to:
claims@simply.co.za
Or post to:
Simply Financial Services
3rd Floor, Grove Exchange
9 Grove Avenue, Claremont 7945

This claim form is your personal statement of your medical condition, for which you are submitting a disability claim. **Please complete this form as comprehensively as possible and do not leave out any information relating to your current or past medical history.** You will also need to fill out a detailed questionnaire about your occupation and your ability to perform your occupation. Your employer will also have to complete a similar set of questions.

SECTION A: INSURED DETAILS

Full names: .....

Surname: .....

ID number: ..... Email address: .....

Physical Address: .....

.....

Landline: ..... Cellphone: .....

Name of medical aid: .....

Medical aid number: ..... Date joined: .....

Family doctor/usual GP: .....

Reason for seeing your family doctor in the past 3 years:

Date consulted	Diagnosis	Treatment received

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SECTION B: POLICY DETAILS

Policy number(s): .....

Date/s of commencement: .....

Please provide details of any other disability policies with any other insurer:

Insurer	Policy start date	Have you submitted a claim?

Comment: .....

.....

SECTION C: CAUSE OF CLAIM

Diagnosis (what are you claiming for?): .....

.....

Date diagnosed: .....

Which doctor/s diagnosed you? .....

Please list the symptoms that led to the diagnosis above: .....

.....

When did you first notice these symptoms? .....

What special tests were done to confirm the diagnosis? .....

.....

..... *Please include dates done and copies of results*

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Do you have any other medical condition/s that you may or may not be taking medication for? .....

.....

.....

On what date were you last at work? .....

When are you likely to return to work? .....

SECTION D: TREATMENT

Please list all treatment received for this condition, including medication and dosages: .....

.....

.....

.....

.....

What side effects of treatment are you currently experiencing? .....

.....

.....

Planned future treatment: .....

.....

.....

Provide details on any rehabilitation program you have undergone or plan to undergo: .....

.....

.....

.....

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Dates of any hospitalisation(s):

Date of hospitalisation	Diagnosis	Treatment received	Outcome

SECTION E: MEDICAL PRACTITIONERS

Treating GP for this condition: .....

Treating specialist/s for this condition (please include speciality): .....

.....

.....

Are you seeing any other healthcare practitioner/s currently (e.g. physiotherapist, homeopath, chiropractor etc. Please provide their details.) .....

.....

.....

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SECTION F: CURRENT FUNCTIONAL HEALTH STATUS

Please comment on your current ability to perform the following activities:

Activity	Independent	Need some help	Need full assistance
Dressing			
Bathing/showering			
Going to the toilet			
Feeding yourself			
Personal grooming			
Washing your hair			
Preparing a meal			
Cleaning the house			
Driving a car			
Using public transport			
Climbing stairs			
Using a computer			
Managing finances			
Grocery shopping			

What is your greatest difficulty at present? .....

.....

.....

.....

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How has your health improved over the past few months? .....

.....

.....

.....

What needs to change to allow you to go back to work? .....

.....

.....

.....

.....

SECTION G: DECLARATION

- I hereby confirm that the above information is true and accurate as supplied by myself.
- I have read and understand the terms and conditions of my policy.
- I furthermore give the insurer consent to obtain further medical evidence or to contact my medical specialists or healthcare providers to discuss my condition in further detail.
- I acknowledge that all information asked for in this form is taken into account when assessing the payment of benefit. **Please also remember that if you do not answer the questions fully and accurately, the benefit may not be paid.**
- I understand that the Simply Financial Services (Pty) Ltd and Hollard Life Assurance Company Limited will keep my personal information protected as required by South African Law, and will only share the information with a third party for the purposes of assessment of the claim.

Claimant name: .....

Claimant signature: ..... Date (dd/mm/yy): : .....