

Email completed & signed documents to:

claims@simply.co.za

Or post to:

Simply Financial Services
3rd Floor, Grove Exchange
9 Grove Avenue, Claremont 7945

Form in support of Terminal Illness Claim on Simply Life benefit

To be completed by the Medical Attendant (treating specialist)

Dear Doctor,

The 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:

Surname:

Address:

.....

Email address:.....

Telephone: Cellphone:

Practice number: HPCSA registration number:

Qualification:

SECTION B: LIFE INSURED DETAILS

Full names:

Surname:

Policy number: ID number:

Name of hospital/clinic: Hospital/clinic file number:



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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? (yes/no)

.....

Please complete the table below in respect of the life insured's background medical history

Consultation date	Clinical presentation/symptoms	Diagnosis	Treatment prescribed	Specialist referral/further investigation	Compliance with treatment

Has the insured ever been tested for HIV antibodies? (yes/no)

.....

Date:

Result:

.....

Please attach results



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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: Surname:

Dated at:

Date (dd/mm/yy):

.....

Doctor's signature:



THE COST INCURRED IN
COMPLETING THIS FORM IS
FOR THE CLAIMANT'S
ACCOUNT



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