OLD MUTUAL

Licensed Financial Services Provider

STATEMENT BY MEDICAL SPECIALIST DISABILITY BENEFIT CLAIM FORM A

Old Mutual Life Assurance Company (South Africa) Limited reg. no: 1999/004643/06

Please print in block letters using black or blue ink.

DETAILS OF CLAIMANT

Policy number(s):

First name(s):

Surname:

ID number:

Date of birth: d d m m c c y y

Address:

Postal code:

Telephone number(s): (W) ( ) (H) ( )

REQUEST TO MEDICAL SPECIALIST, HOSPITAL OR CLINIC

Doctor's name:

Doctor's address:

NB: ANY ADDITIONAL TEST(S) TO BE DONE BEFORE EXAMINATION MUST BE CONFIRMED BY CLAIMS DISABILITY DEPARTMENT – TELEPHONE 0860 10 2274.

Please complete the Confidential Medical Report on the overleaf in respect of the functional impairment for which you have been treating me.

I authorise you to disclose to Old Mutual any information you may have concerning my health and habits.

The fee as agreed to between the Medical Association of South Africa and the Life Offices' Association of South Africa will be paid by myself.

Please forward this report to:

The Department Head
Claims Department
Old Mutual
PO Box 1759
CAPE TOWN
8000.

Yours sincerely

Signature of claimant

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1. DETAILS OF CLAIMANT'S CONDITION

(a) When were you first consulted in connection with this functional impairment?

d d m m c c y y

(b) Date of commencement of sickness or injury/accident:

d d m m c c y y

(c) State dates of all subsequent consultations regarding this impairment.

d d m m c c y y

d d m m c c y y

(d) Are you still in attendance? Yes ☐ No ☐

If yes, state date of last consultation:

d d m m c c y y

Is this form being completed after an examination or from records?

(e) What was the exact cause of impairment (e.g. accident, illness)?

2. PATHOLOGY

(a) Describe in full the claimant's present condition, stating the precise nature, extent and/or severity of the illness or injury/loss of vision/limbs.

(i) State percentage paralysis or loss of use of any affected limbs.

Left leg ☐☐☐ % Right leg ☐☐☐ % Left arm ☐☐☐ % Right arm ☐☐☐ %

(ii) State visual acuity per Snellen Chart with correction.

Left eye ☐☐☐ % Right eye ☐☐☐ %

(b) Is the present impairment total and permanent? Yes ☐ No ☐

If no, what are the chances of recovery (partial or complete)?

What is the probable duration of impairment?

(c) Describe the present treatment.

(d) How often does the claimant require treatment?

(e) How well does the claimant follow the regimen?

(f) How successful has the treatment been?

(g) How do you assess the claimant's rehabilitation potential?

(h) In your opinion, are there any other steps which Old Mutual or the employer could take in order to facilitate rehabilitation?

(i) In your opinion, is the life expectancy of the claimant impaired by the condition? If so, to what extent?

(j) What is the prognosis for recovery?

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3. PARTICULARS OF OCCUPATION(S)

(a) What was the claimant's occupation(s) immediately before his/her current impairment?

(b) Detail in simple terms exactly what limits the claimant (symptomatically or physically) in doing his/her normal work and substantiate this with a full clinical assessment. **Without these details the claim cannot be assessed.**

(c) When was the claimant last able to undertake any part of the duties of his/her occupation?

d d m m c c y y

(d) Do you think that the claimant's impairment will in the future prevent him/her from engaging in his/her own occupation? Yes ☐ No ☐

If not, when can the claimant resume his/her occupation?

d d m m c c y y

(e) What restrictions are placed on the claimant performing a gainful occupation? Please justify your answer.

(f) When is the claimant likely to be able to follow such occupation(s)?

d d m m c c y y

4. MEDICAL HISTORY

(a) Was the claimant referred to any other medical practitioner or was he/she hospitalised? Yes ☐ No ☐

If so, state name(s) and address(es) of medical practitioner(s) and hospital(s) involved, and referral date(s).

Name	Address	Illness	Date	Duration

(b) Has the life assured ever been tested for HIV antibodies? Yes ☐ No ☐

If so:

Date

d d m m c c y y

By whom?

What was the result? ☐ Positive ☐ Negative

(c) If positive, was the life assured informed of the result and when did this happen? Yes ☐ No ☐

(d) Is there any reason to believe that the life assured's impairment is in any way due to or arose directly or indirectly, entirely or partially from AIDS or HIV infection? Yes ☐ No ☐

If so, give full details.

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5. CAUSES OF AND CONTRIBUTIONS TO IMPAIRMENT(S)

State fully if any of the following contributed to or caused a predisposition to the claimant's impairment.

(a)	Previous illness or injury	Yes ☐	No ☐	(f)	Psychological disorder	Yes ☐	No ☐
(b)	Consumption of alcohol	Yes ☐	No ☐	(g)	Terrorist activity	Yes ☐	No ☐
(c)	Taking of drugs (other than under the direction of a registered medical	Yes ☐	No ☐	(h)	Invasion, rebellion, war or other military action	Yes ☐	No ☐
(d)	Attempted suicide	Yes ☐	No ☐	(i)	Other	Yes ☐	No ☐
(e)	Congenital disorder	Yes ☐	No ☐				

If any questions in 5 were answered "YES", please comment fully.

6. IMPACT OF ILLNESS AND INJURY

To enable us to assess the claimant's functional ability to perform various occupations, would you please indicate to what extent the claimant is likely to be able to perform each of the following activities.

ACTIVITY, TASK OR FUNCTION	Relative ability to attend to activity – e.g. impossible, possible subject to great/some pain/discomfort, dangerous to himself/others, no limitation.	Is this ability likely to improve, deteriorate or remain constant? If possible, please estimate the period over which any change may take place.
Clerical or administrative work (sedentary occupations)		
Thinking clearly and making decisions		
Interacting with people in the workplace – customers, colleagues, etc.		
Supervising other staff		
Walking (non-strenuous) over level ground		
Walking (strenuous) over uneven ground, climbing (e.g. into roofs of houses, etc.), working in cramped conditions		
Operating heavy machinery		
Operating light machinery		
Carrying heavy weights		
Carrying light weights – including, for example, mail deliveries		
Driving a light motor vehicle		
Driving a heavy motor vehicle, including graders, etc.		
Manual labour, e.g. digging holes, pushing barrows		
Working in a dusty environment, e.g. a mill or factories working with fibrous materials		
Performing limited work in a sheltered environment – e.g. weaving baskets, drawing/art, switchboard operation		

Please add any general comments which you feel are necessary in order to clarify the above.

I certify that I have personally attended the patient and that all the foregoing statements are correct to the best of my knowledge.

Qualifications:

Initials and surname:

Address:

Practice number:

Telephone number(s): (W) ( ) (H) ( )

Signed at this day of 20

Signature of medical attendant

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The Green Room 11.2005 WT258341