



GREENLIGHT

NAM

Functional and Physical Impairment Benefits Claim Form Statement by Medical Specialist

GREENLIGHT Plan Number (e.g. 12345678)

Grid for Plan Number

Intermediary Code (e.g. PFA: A123456 BROKER: 78870)

Grid for Intermediary Code

Please print in block letters using black or blue ink.

DETAILS OF CONTRACTING PARTY

Form for Contracting Party details including name, ID, address, and telephone numbers.

DETAILS OF LIFE COVERED

Form for Life Covered details including name, ID, address, and telephone numbers.

REQUEST TO MEDICAL SPECIALIST, HOSPITAL OR CLINIC

Form for Medical Specialist details including name and address.

Please complete the Confidential Medical Report overleaf in respect of the disease or disorder for which you have been treating the Life Covered. I authorise you to disclose to Old Mutual any information you may have concerning the Life Covered's health and habits. The fee will be paid by myself.

Please forward this report to: GREENLIGHT Service Centre PO Box 165 Windhoek Namibia Tel. 061 239 527 Fax. 061 246 795

Yours sincerely

Signature of life Covered

Signature box

## MEDICAL HISTORY

Who referred this patient to you? Please provide us with a name and contact number.

Doctor's name	
Contact number	

Has the patient consulted any other medical practitioner or has he/she been hospitalised for this or any other condition?

YES  NO

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

Name	Address	Illness	Date	Duration

Is the patient a member of a medical aid?

YES  NO

Name of medical aid	
Member number	
Name of main member	

## CURRENT MEDICAL CONDITION

When was this patient's current medical condition diagnosed?

D	D	M	M	Y	Y	Y	Y
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Please provide full details of past and present treatment including medication, rehabilitation, etc.


How has the patient's condition responded to treatment?


Is the patient's current impairment permanent and irreversible?

YES  NO

What is the prognosis for recovery?


Contract number 

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## DETAILS OF LIFE COVERED'S IMPAIRMENT

(Please tick relevant block, supply reports where indicated and answer questions in the spaces provided.)

### Advanced HIV Infection

• Supply copies of specialist reports confirming the diagnosis of full-blown AIDS/Stage IV HIV Infection, including copies of HIV antibody test results.

• What is the Life Covered's CD4 count?

• Please tick the appropriate block if the Life Covered suffers from any of the following conditions/diseases:

Weight loss of more than 10% body weight in less than 6 months

Shingles

Oral thrush

Chronic diarrhoea

Active tuberculosis

Kaposi's sarcoma

Candidiasis of the oesophagus, trachea, bronchi or lungs

Oral hairy leukoplakia

Pneumocystis carinii pneumonia

Extra pulmonary cryptococcus

Cytomegalo virus infection of an internal organ other than the liver

Disseminated atypical mycobacteriosis

Visceral leishmaniasis

### Aphasia/Dysphasia

• Supply copies of specialist reports confirming the diagnosis of aphasia or dysphasia.

• Is the Aphasia or Dysphasia

Total

or Partial

### Arrhythmia

• Supply copies of specialist reports confirming the diagnosis of an arrhythmia, including copies of supporting ECG tracings.

• What is the Life Covered's New York Heart Association classification?

NYHA I

NYHA II

NYHA III

NYHA IV

### Biliary Tract Disease

• Supply copies of specialist reports confirming the diagnosis of biliary tract disease, including copies of all liver function test results.

• Does the Life Covered suffer from recurrent Cholangitis?

Yes  No

• Does the Life Covered have persistent jaundice?

Yes  No

• Please provide test results for the following:

S-bilirubin

µmol/l

### Bladder Impairment

• Supply copies of specialist reports confirming the diagnosis of bladder impairment.

• Does the Life Covered have urinary incontinence as a result of organic pathology?

Yes  No

• Does the Life Covered require a:

– total bladder resection?

Yes  No

– permanent indwelling catheter?

Yes  No

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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**Blindness**

- Supply copies of specialist reports confirming the diagnosis of a total loss of sight in one eye OR the diagnosis of bilateral visual impairment in both eyes.
- Please provide the following test results:
  - Visual Acuity Left eye  Right eye
  - Retinopathy grading
  - Hemianopia Left eye  Right eye
  - Visual field loss to a  degree radius

**Cancer**

- Supply copies of specialist reports and Histology confirming the diagnosis of Advanced Stage Cancer.
- At what stage is the Life Covered's Cancer? Stage
- Complete the following Activities of Daily Living scale regarding the Life Covered's functional abilities.  
Only tick the relevant box if the Life Covered is **unable** to perform the activity.

ACTIVITIES OF DAILY LIVING SCALE (ADL's)		
Activity	Description	Tick relevant box
Bathing	The ability to wash/bathe oneself independently.	<input type="checkbox"/>
Transferring	The ability to move oneself from a bed to a chair independently.	<input type="checkbox"/>
Dressing	The ability to take off and put on one's clothing independently.	<input type="checkbox"/>
Eating	The ability to feed oneself independently.	<input type="checkbox"/>
Toileting	The ability to use a toilet and cleanse oneself thereafter independently.	<input type="checkbox"/>
INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (IADL's)		
Activity	Description	Tick relevant box
Food preparation	The ability to plan and prepare a meal independently.	<input type="checkbox"/>
Maintaining a household	The ability to perform such tasks as laundry, washing dishes, making beds, etc., independently.	<input type="checkbox"/>
Transport	The ability to drive a vehicle or access public transport.	<input type="checkbox"/>
Writing	The ability to take down a message or write one's name and other basic details.	<input type="checkbox"/>
Telephone use	The ability to independently answer the telephone or make a call and hold a basic conversation.	<input type="checkbox"/>
Shopping	The ability to compile lists and shop for items on the list, and pay for these items, independently.	<input type="checkbox"/>

**Chronic Gastrointestinal Disease**

- Supply copies of specialist reports confirming the diagnosis of Chronic Gastrointestinal Disease of an organic nature.
- What is the Life Covered's BMI?

**Chronic Kidney Failure**

- Supply copies of specialist reports confirming the diagnosis of chronic renal failure.
- Please indicate what the Life Covered's test result were for estimated GFR.  ml/min
- Does the Life Covered require:
  - Peritoneal dialysis Yes  No
  - Haemodialysis Yes  No

**Chronic Liver Disease**

- Supply copies of specialist reports confirming the diagnosis of permanent Chronic Liver Failure.
- Please provide test results for the following:
  - S-bilirubin  µmol/l
  - S-albumin  g/l
  - INR
- Does the Life Covered suffer from any of the following:
  - Ascites Yes  No
  - Hepatic Encephalopathy Yes  No
  - Bleeding oesophageal varices Yes  No

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**Chronic Respiratory Disorders**

- Supply copies of specialist reports confirming the diagnosis of Chronic Respiratory Failure.
- Does the Life Covered require home oxygen?
- What are the Life Covered's results for the following:

Yes  No

FEV1  %  
 FVC  %  
 DLco  %

**Chronic Spinal Column Conditions**

- Supply copies of specialist reports confirming the diagnosis of a Spinal Column Disorder, including electrodiagnostic and radiological evidence.
- Does the Life Covered have a cauda equina abnormality?
- Complete the following Activities of Daily Living scale regarding the Life Covered's functional abilities.

Yes  No

Only tick the relevant box if the Life Covered is **unable** to perform the activity.

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**Clotting Disorders**

- Supply copies of specialist reports confirming the diagnosis of a Clotting Disorder.
- Has the disorder resulted in end-organ failure? If so, please elaborate:


**Congestive Cardiac Failure**

- Supply copies of specialist reports confirming the diagnosis of Congestive Cardiac Failure, including copies of echocardiograph results.
- What is the Life Covered's New York Heart Association classification?

NYHA I   
 NYHA II   
 NYHA III   
 NYHA IV

- Is the Life Covered on an official waiting list for a heart transplant?

Yes  No

**Cranial Nerve V Pathology**

- Supply copies of specialist reports confirming the diagnosis of facial neuralgic pain that is resistant to treatment.
- Is the pain/paralysis  bilateral   
or  unilateral
- Does the Life Covered require decompression surgery?

Yes  No

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**Cranial Nerve VII Paralysis**

- Supply copies of specialist reports confirming the diagnosis of Facial Nerve Paralysis.

**Cranial Nerve VIII Paralysis**

- Supply copies of specialist reports confirming the diagnosis of a permanent Vestibulocochlear Nerve Paralysis.
- Complete the following Activities of Daily Living scale regarding the Life Covered's functional abilities.

Only tick the relevant box if the Life Covered is **unable** to perform the activity.

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**Cranial Nerves IX, X, XII Paralysis**

- Supply copies of specialist reports confirming the diagnosis of cranial nerve IX, X, XII paralysis.

**Endocrine Disorders**

- Supply copies of specialist reports confirming the diagnosis of an endocrine disorder.
- Has the disorder resulted in end-organ failure? If so, please elaborate:


**Epilepsy**

- Supply copies of specialist reports confirming the diagnosis of Epilepsy, including copies of all radiological imaging reports.
- How many seizures does the Life Covered have per month?
- Has the Life Covered had seizures for at least 3 consecutive months? Yes  No
- Complete the following Activities of Daily Living scale regarding the Life Covered's functional abilities.

Only tick the relevant box if the Life Covered is **unable** to perform the activity.

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**Facial Disorders or Disfigurement**

- Supply copies of specialist reports confirming that the Life Covered has suffered total Facial Disfigurement.
- Does the Life Covered's disfigurement hinder social acceptance? Yes  No
- Does the Life Covered require reconstructive surgery? Yes  No

**Faecal Incontinence**

- Supply copies of specialist reports confirming the diagnosis of complete Faecal Incontinence.

**Gait Disorders/Poor Motor Co-ordination**

- Supply copies of specialist reports confirming the diagnosis of a Cerebellar Disorder as well as copies of rehabilitation reports e.g. Physiotherapy/ Occupational Therapy reports, detailing the impact of the condition on the Life Covered's physical and functional abilities.
- Complete the following Activities of Daily Living scale regarding the Life Covered's functional abilities.

Only tick the relevant box if the Life Covered is **unable** to perform the activity.

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**Gastrointestinal Stoma**

- Supply copies of specialist reports confirming a gastrointestinal stoma.

**Hearing Loss**

- Supply copies of specialist reports confirming the diagnosis of a loss of hearing in one or both ears.
- Please indicate the Life Covered's Audiometry results for each ear:

- Left ear  dB
- Right ear  dB

**Hemiplegia**

- Supply copies of specialist reports confirming the loss of functioning of one side of the body.

**Hypertension**

- Supply copies of specialist reports confirming the diagnosis of uncontrolled Hypertension, including:
  - blood pressure recordings
  - measurements of kidney functioning
  - Echocardiogram results
  - Fundoscopy findings
  - neurological imaging evidence of a cerebrovascular accident
- What is the Life Covered's New York Heart Association classification?

- NYHA I
- NYHA II
- NYHA III
- NYHA IV

Contract number

**Impaired Consciousness**

- Supply copies of specialist reports confirming the diagnosis of a Coma, including Glasgow Coma Scale results.
- Does the Life Covered require:
  - total medical support
  - assisted ventilation
- What was the duration of the Coma?  hrs or  irreversible

Yes  No   
 Yes  No

**Irreducible Hernia**

- Supply copies of specialist reports confirming the diagnosis of an Irreducible Hernia.
- Complete the following Activities of Daily Living scale regarding the Life Covered's functional abilities.  
 Only tick the relevant box if the Life Covered is **unable** to perform the activity.

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**Loss of use of a combination of upper and lower limbs**

- Supply copies of specialist reports confirming the Life Covered's loss of use of two limb appendages, i.e. feet, legs, hands or arms, including radiographic and electroconduction study results, where appropriate.

**Loss of use of both arms**

- Supply copies of specialist reports confirming the Life Covered's loss of use of both arms, including radiographic and electroconduction study results, where appropriate.

**Loss of use of both legs**

- Supply copies of specialist reports confirming the Life Covered's loss of use of both legs, including radiographic and electroconduction study results, where appropriate.

**Loss of use of one arm**

- Supply copies of specialist reports confirming the Life Covered's loss of use of one arm, including radiographic and electroconduction study results, where appropriate.

**Loss of use of one foot**

- Supply copies of specialist reports confirming the Life Covered's loss of use of one foot, including radiographic and electroconduction study results, where appropriate.

**Loss of use of one hand**

- Supply copies of specialist reports confirming the Life Covered's loss of use of one hand, including radiographic and electroconduction study results, where appropriate.

**Loss of use of one leg**

- Supply copies of specialist reports confirming the Life Covered's loss of use of one leg above or below the knee or through disarticulation at the hip joint, including radiographic and electroconduction study results, where appropriate.

**Loss of use of one thumb**

- Supply copies of specialist reports confirming the Life Covered's loss of use of one thumb, including radiographic and electroconduction study results, where appropriate.

**Major Burns: Third Degree**

- Supply copies of specialist reports confirming that the Life Covered has suffered third degree burns.
- Please confirm the percentage of total body surface area involved.  %

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**Organic Brain Disorders/Dementia**

- Supply copies of specialist reports confirming the diagnosis of Dementia.
- What does the Life Covered score on the Clinical Dementia Rating Scale?
- How much supervision does the Life Covered require with everyday duties?  
None       Some       Constant

**Paraplegia/Diplegia**

- Supply copies of specialist reports confirming the loss of use of either both lower limbs or both upper limbs.

**Peripheral Arterial Disease**

- Supply copies of specialist reports confirming the diagnosis of Peripheral Arterial Disease, including copies of Doppler readings.
- Does the Life Covered suffer from any of the following:
  - Severe vascular ulceration Yes       No
  - Gangrene secondary to peripheral arterial disease Yes       No
  - Cold leg Yes       No
  - Pain on exercise with claudication on walking less than 500 m Yes       No

**Peripheral Venous Disease**

- Supply copies of specialist reports confirming the diagnosis of Peripheral Venous Disease.

**Psychiatric Disorders**

- Supply copies of specialist reports confirming the diagnosis of a Psychiatric Disorder, including classification on the DSM IV (or the latest version thereof) multi-axial system.
- What is the Life Covered's score on the Global Assessment of Functioning Scale?
- Does the Life Covered require constant supervision for self care? Yes       No
- Has the Life Covered been institutionalised? Yes       No

**Pulmonary Hypertension**

- Supply copies of specialist reports confirming the diagnosis of permanent Pulmonary Hypertension.
- What is the Life Covered's pulmonary artery pressure?
- What is the Life Covered's New York Heart Association classification?  
NYHA I   
NYHA II   
NYHA III   
NYHA IV

**Quadriplegia**

- Supply copies of specialist reports confirming the total and permanent loss of functioning of both upper and lower limbs.

**Red Blood Cell Disorders**

- Supply copies of specialist reports confirming the diagnosis of severe Anaemia.
- Please indicate the Life Covered's haemoglobin levels:  g/dL
- How many blood transfusions does the Life Covered require per week?

**Speech Impairment**

- Supply copies of specialist reports confirming the diagnosis of a loss of the ability to speak OR the diagnosis of a Speech Impairment.

**Systemic Skin Disorder**

- Supply copies of specialist reports confirming the diagnosis of a Systemic Skin Disorder.

**White Blood Cell Disorders**

- Supply copies of specialist reports confirming the diagnosis of a severe White Blood Cell Disorder.
- Please indicate the Life Covered's absolute Neutrophil Count:
- Has the Life Covered been diagnosed with Lymphoma or Leukaemia? Yes       No
- If yes, please indicate how many chemotherapy treatments are required per year.
- How many hospitalisations has the Life Covered previously had per year, due to acute bacterial infections?

Contract number

**Activities of Daily Living**

- Supply copies of specialist reports confirming the Life Covered's impairment.
- Complete the following Activities of Daily Living scale regarding the Life Covered's functional abilities.

Only tick the relevant box if the Life Covered is **unable** to perform the activity.

<b>ACTIVITIES OF DAILY LIVING SCALE (ADL's)</b>		
<b>Activity</b>	<b>Description</b>	<b>Tick relevant box</b>
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<b>INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (IADL's)</b>		
<b>Activity</b>	<b>Description</b>	<b>Tick relevant box</b>
Food preparation	The ability to plan and prepare a meal independently.	
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Shopping	The ability to compile lists and shop for items on the list, and pay for these items, independently.	

**DECLARATION BY MEDICAL SPECIALIST**

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

Signed at  this  day of  20

Signature of medical specialist

Initials

Surname

Practice number

Qualifications

Address   
 Postal code

Telephone Code  Number

Fax Code  Number

Contract number