Declaration by attending doctor for confirmed and symptomatic Covid-19 (Corona Virus) claim

Important:

- *To be completed by the attending doctor only. (If abroad, provide all medical documentation in English)*
- ***In accordance with the amended regulations: only claims where the claimant has tested positive and demonstrates symptoms and clinical signs, will be considered.***
- *An accurately completed form is essential in order to avoid delays in the assessment process. Please complete all questions.*
- *Legible copies of original documents may be submitted instead of the originals. We require a confirmatory PCR test or antigen test.*

Please supply the following additional completed document:

- Legible copies of certificates of illness provided by attending doctor. *(If available.)*

Contact details for Living Benefit Claims

Telephone number: (021) 916-3455
Fax number: (021) 947-5804
e-mail address: sickness@sanlam.co.za

Plan number(s) _____

Particulars of claimant

Surname _____

Full first names _____

Date of birth _____ *(dd/mm/ccyy)*

Residency: SA resident ☐ Non-SA resident ☐ (Specify) _____

Current residential address _____

_____

General practitioner's contact details:

Name and surname of treating doctor _____

Contact number _____

Signature of consulting doctor _____

How was your consultation with the patient done? Please mark below:

Telephonic ☐ Face to face ☐ Other* ☐ (Specify if "other") _____

Please comment on the symptoms reported by your patient

Date of symptom onset: _____ *(dd/mm/ccyy)*

Symptoms (tick all that apply):

Fever (≥38°C) ☐ Cough ☐ Chills ☐ Sore throat ☐ Shortness of breath ☐

Vomiting ☐ Diarrhoea ☐ Myalgia/body pains ☐ No symptoms yet/currently ☐

Other ☐ (Specify if "other") _____

Underlying factors/comorbid conditions/treatment/management

Please comment on any chronic condition including immuno-compromised state as well as immune-suppressive therapy:

_____

_____

Recommendation to patient

☐ Self-isolation/quarantine _____

☐ Laboratory screening, if no lab testing done, comment on reason _____
(If no lab testing, please include proof of the rapid antigen test)

☐ Discharge, if yes, please specify the date _____ *(dd/cc/mmyy)*

☐ Currently hospitalised _____

☐ Transferred Name of facility _____

☐ Other (specify) _____

Dates for recommended quarantine or sick leave

From: _____ (dd/mm/ccyy) to _____ (dd/mm/ccyy)

Primary diagnosis _____

Diagnostic code (ICD -10) for primary diagnosis _____

Secondary diagnosis _____

Diagnostic code for secondary diagnosis (ICD -10) _____

NB - Prolonged/extended sick leave period

Were there any complications/comorbidities, which prolonged the sick leave beyond what can be reasonably expected for a condition of this nature? *(Please include copies of specialist reports.)*

Yes ☐ No ☐

If "Yes", please comment on these complications as well as the reason for the extended sick leave.

_____

_____

_____

_____

_____