Print form Save form

Declaration by attending doctor for an Income Protector / Overhead expenses Protector claim

Important:

- *To be completed by the attending doctor only. (If abroad, provide all medical documentation in English)*
- *Any cost involved to complete this form is the responsibility of the claimant.*
- *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.*

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: livingbenefits@sanlam.co.za

Plan number(s) _____

Particulars of claimant

Surname _____

Full first names _____

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

Nature of claim and particulars of consultations

The claimant first consulted me for this current condition on _____ *(dd/mm/ccyy)*

Follow-up consultation dates _____ *(dd/mm/ccyy)*

_____

_____

_____

Primary diagnosis _____

Diagnostic code (ICD -10) for primary diagnosis _____

Secondary diagnosis _____

Diagnostic code for secondary diagnosis (ICD -10) _____

As a result of the above diagnosis the claimant was **totally** unable to fulfil his/her professional duties for the period (Please also include weekends if they form part of the sick leave period granted) :

From _____ *(dd/mm/ccyy)* To: _____ *(dd/mm/ccyy)*

Was the sick leave due to: Illness ☐ Injury ☐ *(Please mark the applicable option with an X.)*

Describe the nature/details of the illness or injury

_____

_____

Date when the illness first started/injury occurred _____ *(dd/mm/ccyy)*

Was the claimant hospitalised? Yes ☐ No ☐

If "Yes": Admission date: _____ *(dd/mm/ccyy)* Discharge date: _____ *(dd/mm/ccyy)*

Time of admission: _____ Time of discharge: _____

Was any surgery performed? Yes ☐ No ☐

If "Yes", please specify the type of operation/procedure.

_____

_____

Plan number(s) _____

Nature of claim and particulars of consultations *(continuation)*

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

Operation code (CPT4) _____

Were there any complications, 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.

_____

_____

_____

_____

_____

Is the insured currently at work? Yes ☐ No ☐

Particulars of doctor

Full names and surname _____

Medical Board Registration Number _____

Qualification _____

Practice number _____

Telephone number (_____) _____ Fax number (_____) _____

Postal address _____

_____

e-mail address _____

Signature of doctor _____

Date _____ *(dd/mm/ccyy)* Place _____