Confidential

EB2298E

Medical Certificate: Proof of continuation of disability

Please return the completed form to: **Sanlam Corporate: Group Risk - Disability Claims**

E-mail address EBDisabilityClaimsBenefits@sanlam.co.za Fax number (021) 947-3207
Postal address PO Box 1, Sanlamhof, Bellville 7532

Important:

Please provide the following to Sanlam:

- Specialist reports in your possession.
- Please include your account for completing this form.

1. Particulars of insured

Surname _____

Full names _____

Previous name *(if applicable)* _____

Date of birth _____ *(dd/mm/ccyy)* Gender Male ☐ Female ☐

Country of birth _____

Type of identification Identity document* ☐ Passport ☐ *copy of applicable document compulsory*

Number _____ Country of issue _____

Passport expiry date _____ *(dd/mm/ccyy)*

**Provide a copy of your Identification document or Identification Smart card (copies of both sides)*

Country and/or Country of citizenship/Nationality RSA ☐ Other country Yes* ☐ No ☐

* If "Yes", please give other country _____

Address and contact numbers

Residential address _____

_____ Postal/Zip code _____

Postal address *(if it differ from the residential address)* _____

_____ Postal/Zip code _____

e-mail address _____

Cell/Mobile _____ Other contact number (h) _____ (w) _____

2. Report by medical practitioner

2.1 Since when has the insured been treated by you? _____

2.2 What symptoms is the insured experiencing which affect his/her ability to work?

Symptom	Date of commencement / duration

Full names and surname of insured _____

2.3 What, according to the diagnosis(es), is the cause of the symptoms?

Illness	Degree of seriousness	Date of diagnosis / duration

2.4 What are the complications or target organ impairment? _____

2.5 Is the insured aware of the diagnosis? Yes ☐ No ☐

2.6 On what date was he/she informed of the diagnosis? _____ *(dd/mm/ccyy)*

2.7 Nature and duration of treatment applied:

_____

_____

2.8 To what extent could further treatment alleviate the symptoms?

_____

2.9 Date of most recent examination of the insured _____ *(dd/mm/ccyy)*

2.10 To qualify for a claim in terms of the disability benefits, the insured must be continuously and totally prevented from engaging in his/her regular occupation, as well as any other occupation that he/she could reasonably be expected to pursue, taking into account his/her training or experience.

2.10.1 Do you regard the insured as disabled according to the above definition: *(Please mark the applicable option and explain why)*

- in respect of his/her regular occupation? ☐ _____
- in respect of any other occupation? ☐ _____

2.10.2 Why was the insured unable to perform the essential duties connected:

- with his/her regular occupation? _____
- with any other occupation? _____

2.10.3 What part of the duties connected:

- with his/her regular occupation can the insured perform? _____
- with any other occupation can the insured perform? _____

2.10.4 Will he/she possibly again be able to perform all the duties connected:

- with his/her regular occupation Yes ☐ No ☐
  If "Yes", when? _____ *(dd/mm/ccyy)*
- with any other occupation Yes ☐ No ☐
  If "Yes", when? _____ *(dd/mm/ccyy)*

2.10.5 Will the use of aids, eg. wearing a corset, using a wheelchair, wearing built-up shoes, etc. enable the insured to follow:

- his/her regular occupation? Yes ☐ No ☐
  If "Yes", when? _____ *(dd/mm/ccyy)*
- any other occupation? Yes ☐ No ☐
  If "Yes", when? _____ *(dd/mm/ccyy)*

2.11 Is excessive use of alcohol or drugs contributing to the symptoms/illness? Yes ☐ No ☐

If so, since when has the use been excessive? _____ *(dd/mm/ccyy)*

If treatment has been received, please indicate since when and which institution has provided this service. _____

Full names and surname of insured _____

2.12 Since when has the insured been unable to follow his/her regular occupation on account of his/her disability?

Date _____ *(dd/mm/ccyy)*

2.13 Are you convinced that at present he/she is totally unable to work? Yes ☐ No ☐

2.14 Please give any additional information that you regard as important for the assessment of the insured's inability to pursue his/her occupation:

_____

_____

2.15 According to your experience, do most people engaging in a similar occupation and suffering a similar degree of illness, still find it possible to pursue their occupation? Yes ☐ No ☐

2.16 Please supply the following information regarding other doctors who treated the insured for the abnormalities/disorders relating to the disability:

Name of medical practitioner	Address of medical practitioner	Illness	Date *(dd/mm/ccyy)*	Duration

2.17 Which proposals would you submit to enable us and the employer to rehabilitate the insured so that in his/her own interest, he/she will be able to make a proper living?

_____

_____

2.18

Please provide full details of previous or other abnormal physical or mental conditions not relating to the disability	When did the insured become aware of it?	When was a medical practitioner first consulted about it?

2.19 Would an operation, if not too risky, improve the insured's ability to work? Yes ☐ No ☐

If so, would you say that any other reasonable person would undergo the operation?

_____

_____

2.20 Further information:

_____

_____

Full names and surname of insured _____

2.21 Would you recommend that we also consult a specialist in connection with the insured's disability? Yes ☐ No ☐

2.22 To your knowledge was the insured at any stage tested for HIV antibodies? Yes ☐ No ☐

If "Yes", was the insured found HIV-positive? _____

3. Particulars of medical practitioner

Full names and surname _____

Practice number _____

Address _____

E-mail address _____

Telephone number ( ) _____

Qualifications _____

Bank particulars

Account holder _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Type of account Current ☐ Savings ☐ Transmission ☐ Other ☐ _____ *(specify)*

Signature of medical practitioner _____

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