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

For Namibian policies refer to: claims.affluentsupport@sanlam.com.na or contact our Sanlam Namibia office at +264 61 294 7440.

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

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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.

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Licensed Financial Services and Registered Credit Provider (NCRCP43)

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.

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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 ______________________

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