



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)

_____ (dd/mm/ccyy)

_____ (dd/mm/ccyy)

_____ (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 _____