Hollard.

DISABILITY CLAIM FORM

(To be completed by medical attendant)

Please note that Hollard Life will not pay for the completion of this form.

Your claim will only be considered if every question has been completed in full.

The following must be included when submitting this form to assess the claimant's degree of impairment (medical assessment), and to ascertain:

a. Diagnosis
b. Alteration(s) of functional capacity due to illness or injury
c. Optimal medical treatment

Return the completed form and the above documents to lifeclaims@hollard.co.za or fax to 086 659 0135.

1. Policy details

Policy no. _____ Identity no. _____

Name of insured _____

Policyholder _____

Employer's name _____ Occupation _____

2. Medical Information

1. Date of first consultation D D M M Y Y Y Y
2. Date of last consultation D D M M Y Y Y Y
3. Date of diagnosis of the patient's illness D D M M Y Y Y Y
4. What was the diagnosis of the patient's condition? _____
5. What were the symptoms? _____
6. When did the first symptoms of the condition appear? D D M M Y Y Y Y
7. What has caused the disability? _____
8. What are the resultant limitations experienced? _____
9. Provide details of any complications or concurrent conditions _____
10. Are you still attending to the patient? YES ☐ NO ☐
11. Does the patient have insight into his/her illness? YES ☐ NO ☐

12. Provide details of all consultations in the last five years

Date	Reason for consultation	Diagnosis	Treatment	Outcome

13. Has the patient ever been hospitalised? YES ☐ NO ☐

Provide details of hospitalisation

From	To	Reason for hospitalisation	Hospital/Doctor	Treatment	Outcome

14. Has the patient been referred to any health care professional (Physiotherapist, Occupational Therapist, Psychologist or other medical specialists, etc.)? YES ☐ NO ☐

Provide details

Name	Designation	From	To	Treatment	Outcome

15. Have any of the following contributed in any way to the patient's disablement?

Nature of contributor, and give details:

Previous illness or injury Y ☐ N ☐ _____

Hazardous pursuit or pastime Y ☐ N ☐ _____

Habits (e.g. excessive alcohol consumption, smoking) Y ☐ N ☐ _____

Self inflicted injuries Y ☐ N ☐ _____

16. How has the patient's condition been treated?

Date	Therapy/Medication	Description/Dosage

Describe fully, in detail:

Strict compliance by patient with medication/therapy Y N

Is the condition satisfactorily controlled? Y N

Is the patient undergoing optimal therapy? Y N

Is future surgery planned/required/anticipated? Y N

If so, when? D D M M Y Y Y Y

Any additional comments

17. Give an indication of the short term and long term prognosis with reasons

2. Assessment scale for activities of daily living

Washing	The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.	☐ Can	☐ With help	☐ Cannot
Mobility	The ability to move indoors from room to room on level surfaces and outdoors for 200m on level surfaces.	☐ Can	☐ With help	☐ Cannot
Transferring	The ability to move from a bed to an upright chair or wheelchair and visa versa.	☐ Can	☐ With help	☐ Cannot
Dressing	The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	☐ Can	☐ With help	☐ Cannot
Feeding	The ability to cut food as well as be able to get food and/or drink to the mouth.	☐ Can	☐ With help	☐ Cannot
Toileting	The ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate. The maintenance of continence is included in this Activity of Daily Living.	☐ Can	☐ With help	☐ Cannot

Communicating	The ability to answer the telephone and take a message.	☐ Can	☐ With help	☐ Cannot
Reading	Having the eyesight required to be able to read a newspaper, book or magazine.	☐ Can	☐ With help	☐ Cannot
Bending and lifting	The ability to get in and out of a standard size car, bend, kneel or pick up something from the floor, lift, carry or move everyday objects.	☐ Can	☐ With help	☐ Cannot
Co-ordination	Co-ordination – being the ability to use hands and fingers with precision, including the ability to pick up and manipulate small objects, such as pens or cutlery.	☐ Can	☐ With help	☐ Cannot

18. In your opinion at which date was the patient last able to work? D D M M Y Y Y Y

19. When is the patient expected to return to work? D D M M Y Y Y Y

20. In your opinion when will the patient be able to engage in any part of his/her occupation:

a) Part time: Admin ☐ Sedentary ☐ Travel ☐ Manual ☐ Supervisory ☐ D D M M Y Y Y Y

b) Full time: Admin ☐ Sedentary ☐ Travel ☐ Manual ☐ Supervisory ☐ D D M M Y Y Y Y

If the patient has already recovered and returned to work, please give the date of his/her return D D M M Y Y Y Y

IF ADDITIONAL INFORMATION OR REPORTS ARE AVAILABLE, PLEASE INCLUDE COPIES OR ORIGINALS OF THESE DOCUMENTS. ANY ORIGINALS WILL BE RETURNED.

ALL THE INFORMATION GIVEN IS CORRECT AND TRUE

3. Notice to medical attendants

Practice no. _____

Tel. no. _____ Fax no. _____

Full name _____

Email address _____

Postal address _____

Declaration by medical attendant

I declare that the statements above are true and complete.

Signature _____ **Date** D D M M Y Y Y Y

Hollard Declaration

We respect and adhere to patient confidentiality and data privacy principles in relation to Personal Information. We will therefore only process this information for the purpose for which it is intended.