PMA – REQUEST FORM

Dear Dr _____

Your patient has applied to Hollard Life for life insurance, and is most anxious that his/her application is accepted as soon as possible.

Policy details

Policy no. _____ Identity no. _____

Name of insured _____

In order to assess our client's state of health we require your assistance by the completion of the attached form.

- **We would appreciate sight of all reports and tests done**
- **Please supply specific details regarding current symptoms, treatment and prognosis.**
- **We would appreciate special reference to:**

Re: _____

By agreement with the Medical Association of South Africa a statement is incorporated in Hollard Life's application and the medical report forms which has been signed by the life to be assured.

In this agreement we are authorised to seek and obtain medical information from any Doctor who has attended to him/her.

Please forward the completed PMA to ds_uwrequirements@hollard.co.za.

PERSONAL MEDICAL ATTENDANT'S REPORT (PMA)

APPLICANT'S DETAILS

Full name _____

Date of birth _____ Policy no. _____

How long have you been the applicant's usual medical attendant? _____

1. Clinical History

Please give a summary of any significant symptoms, illnesses (specifically if the patient is on treatment for hypertension, diabetes mellitus, ischemic heart disease etc). Please indicate treatment and efficacy of control. Please specify accidents or consultations, which may affect your patient's health, life expectancy or ability to perform his/her own or similar occupation.

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Initials

2. Investigations

(a) Please give latest results and dates of routine blood pressure and urine examinations.

(b) Please enclose any special investigations, e.g. ECG's, x-rays, blood tests, etc. done during the past 5 years.

3. General

(a) Has your patient consulted any other doctor, hospital or clinic? YES ☐ NO ☐

If YES, give details

(b) Has your patient ever had any sexually transmitted disease? YES ☐ NO ☐

If YES, give details

(c) Do you know of anything that may influence your patient's health, life expectancy or ability to perform his/her own or other occupation? YES ☐ NO ☐

If YES, give details

Declaration

I/we declare all the information disclosed herein to be true and accurate in every respect.

Signed at _____ Date Y Y Y Y M M D D

Name of Medical attendant _____

Signature of Medical attendant

Hollard Life will reimburse all medical accounts issued according to the insurance billing code A1401 or A4103.

Full name _____

Qualifications _____ Practice no. _____

Work tel. no. _____ Cell no. _____

Email address _____

Postal address _____

Please send your account to ds_doctoraccount@hollard.co.za.

Hollard declaration

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