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RETEST OF BLOOD PRESSURE

(To be completed by the medical attendant)

Please return this completed form to ds_uwrequirements@hollard.co.za.

1. Life insured's details

Policy no. ____________________ Identity no. ____________________

Name of insured ____________________

Kindly assess the above applicant's blood pressure 3 times at 5-minute intervals, with him/her in the recumbent position and as relaxed as possible.

Occasion	Time	Reading
First		
Second		
Third		

Have you ever taken this applicant's blood pressure in the past? YES ☐ NO ☐

If YES, give readings obtained with relevant dates

____________________ D D M M Y Y Y Y

____________________ D D M M Y Y Y Y

Is the client currently on treatment for hypertension? YES ☐ NO ☐

If YES, please supply details ____________________

2. To be completed by the life insured

Are you at present receiving, or have you during the past 2 years received, treatment for raised blood pressure? YES ☐ NO ☐

If YES, give the date on which the treatment started and details of the treatment D D M M Y Y Y Y

Signature (life insured) ____________________ **Date** D D M M Y Y Y Y

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3. Medical attendant billing details

Hollard Life will reimburse all medical accounts issued according to the insurance billing code A1106.

Full name ______________________________

Qualifications ____________________ Practice no. ____________________

Work tel. no. ____________________ Cell no. ____________________

Email address ______________________________

Postal address ______________________________

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

4. Declaration by medical attendant

I declare that the statements above are true and complete.

Signature (medical attendant) ____________________ **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.