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:
> Diagnosis
> Alteration(s) of functional capacity due to illness or injury
> Optimal medical treatment

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

Policy details

Policy no. | ID no.

Name of insured

Policy owner

Employer | Occupation

1. Date of first consultation (Y Y Y Y M M D D)
2. Date of last consultation (Y Y Y Y M M D D)
3. Date of diagnosis of the claimant's illness (Y Y Y Y M M D D)
4. What was the diagnosis of the claimant's condition?
5. What were the symptoms
6. When did the first symptoms of the condition appear? (Y Y Y Y M M D D)
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 claimant? (Y N)
11. Does the claimant have insight into his/her illness? (Y N)

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

Date	Reason for consultation	Diagnosis	Treatment	Outcome

13. Has the claimant ever been hospitalised? Y N

Provide details of hospitalisation

Date	To	Reason for hospitalisation	Hospital/Doctor	Treatment	Outcome

14. Has the claimant been referred to any health care professional (Physiotherapist, Occupational Therapist, Psychologist or other medical specialists etc)? Y N

Provide details

Name	Designation	From	To	Treatment	Outcome

15. Have any of the following contributed in any way to the claimants 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 claimant with medication/therapy	Y N	
Is the condition satisfactorily controlled?	Y N	
Is the claimant undergoing optimal therapy?	Y N	
Is future surgery planned/required/anticipated?	Y N	
If so when?	Y Y Y Y M M D D	

Any additional comments

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

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
Toiletting	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 & 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 everday objects.	Can	With Help	Cannot
Cordination	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 claimant last able to work?

19. When is the claimant expected to return to work

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

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

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

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

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

ALL THE INFORMATION GIVEN IS CORRECT AND TRUE

Notice to medical attendants

Practice no.

Tel no. Fax no.

Full name

E-mail address

Postal address

Declaration by medical attendant

I declare that the statements above are true and complete.

Signature Date Y Y Y Y M M D D