

## CRITICAL ILLNESS BENEFIT CLAIM FORM – MEDICAL ATTENDANT’S REPORT

Please return to: Hollard Group Risk, 1st Floor, 34 Melrose Boulevard, Melrose Arch or Postnet Suite 196, Private Bag X1, Melrose Arch, 2076  
 Tel: (011) 351 5000. Fax: (011) 351 3079. Email: [hgrdisability@hollard.co.za](mailto:hgrdisability@hollard.co.za)

### SECTION A: HOW TO CLAIM

The claimant must obtain at his/her own expense, the medical attendant’s report from a registered medical practitioner, who is not a member of the claimant’s immediate family.

The medical attendant must complete this form to confirm the diagnosis of the critical illness.

It is essential that this form is fully completed to prevent any unnecessary delays due to missing or incomplete information. This form may be submitted to Hollard Life by the employer, claimant or the medical attendant.

#### This form is structured in six sections:

- Section A: How to claim (informative section)
- Section B: Policy details (to be completed by employer or claimant)
- Section C: Claimant’s personal details (to be completed by employer or claimant)
- Section D: Medical attendant’s details (to be completed by the medical attendant)
- Section E: Medical information (to be completed by the medical attendant)
- Section F: Declaration (to be signed by the medical attendant)

#### This fully completed form should be accompanied by the following supporting documentation:

- copies of any reports (e.g. EEG, X-rays, previous consultations, etc.)
- copies of any laboratory results (e.g. histology, blood results etc.)
- copies of any additional information to substantiate the claim

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Life.

### PRIVACY

We respect the confidentiality of your personal information as well as your privacy. If necessary, we may need to share either your and/or the insured’s personal or medical information, or both, with third parties. These third parties are other insurance and/or reinsurance companies, or service providers that may assist us in assessing and managing the risk or servicing you. We impose the same strict confidentiality standards on these third parties as is applied by us. By providing the required personal and medical information, and signing this form, you hereby confirm that you consent to us processing and sharing your personal and medical information with other third parties. We will treat this information with caution and we have put reasonable security measures in place to protect it. The information provided will only be used for its intended purpose and will not be shared within the Hollard Group or another organisation for marketing additional products and/or services to you.

### SECTION B: POLICY DETAILS (to be completed by claimant, before form is completed by medical attendant)

Employer:

Policyholder:

Policy number:

Membership / Employee number:

**SECTION C: CLAIMANT'S PERSONAL DETAILS** (to be completed by claimant, before form is completed by medical attendant)

First names:

Surname:

Identity number:

Date of birth: DDMMYYYY Gender: MF

Residential address:   
 Code:

Postal address:   
 Code:

Home telephone number:

Cell phone number:

Email address:

**SECTION D: MEDICAL ATTENDANT'S DETAILS** (to be completed by medical attendant)

Title:  First names:

Surname:

Qualifications:

Practice Number:

Physical address:   
 Code:

Postal address:   
 Code:

Telephone number:

Fax number:

Email address:

**SECTION E: MEDICAL INFORMATION** (to be completed by medical attendant)

1. What is the diagnosis of the claimant's condition?

2. Does the claimant have a past history of this condition?

Y  N

If "Yes", please provide details.

3. Date of diagnosis of the claimant's condition:

D  D  M  M  Y  Y  Y  Y

4. Please refer to Annexure One for the full definitions of the following critical illness conditions. Please advise which of the following conditions accurately describes the claimant's condition by ticking the applicable critical illness.

- Heart attack – Level A: Heart attack with severe permanent impairment in function
- Heart attack – Level B: Heart attack with mild permanent impairment in function
- Heart attack – Level C: Heart attack with mild impairment
- Heart attack – Level D: Heart attack with almost full recovery
- Coronary artery bypass graft
- Stroke – Level A: Stroke with severe impairment
- Stroke – Level B: Stroke with moderate impairment
- Stroke – Level C: Stroke with mild impairment
- Stroke – Level D: Stroke with almost full recovery
- Cancer – Level A
- Cancer – Level B
- Cancer – Level C
- Cancer – Level D
- Kidney failure
- Major organ transplant
- Loss of limbs
- Major burns
- Total Blindness
- Coma
- Multiple sclerosis
- Alzheimer's Disease
- Motor Neuron Disease
- Parkinson's Disease
- Benign Brain Tumour
- Accidental HIV

5. Please elaborate on the nature of the claimant's condition as selected above.

6. What treatment is the claimant undergoing and state the date of first treatment?

D  D  M  M  Y  Y  Y  Y

**Thank you for your assistance. We wish to advise that we may be requested to provide a copy of this report to other medical practitioners, other insurers and/or legal representatives.**

**SECTION F: DECLARATION** (to be signed and dated by medical attendant)

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life. I declare that I have personally examined and attended to the claimant and that the contents of this report are true and correct. I accept that a copy of this report can be made available to other parties as stated above.

In the event that this claim or any supporting claim documentation is found to be fraudulent or misrepresented, Hollard Life reserves the right to proceed with the appropriate action against the claimant.

I have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information. If I am agreeing to the aforementioned on behalf of someone else, I confirm that I have the necessary approval and/or mandate to do so.

Signed at  on this  day of  20

Name of medical attendant

Signature

**Hollard** is committed to “Creating and securing a better future” and therefore subscribes to an internal Anti-Fraud policy. Please report any suspicious or unethical activity anonymously on 0801 516 170 (toll free) or via email at [Hollard@tip-offs.com](mailto:Hollard@tip-offs.com).