PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

DIRECTIONS TO CLAIMANT

Dear Claimant

To make a claim for a benefit under the policy you must read this document carefully and ensure that you understand what is required of you. Should you have any questions on what to do or how to submit your claim you should contact us on the above numbers. Before you complete any forms you must ensure that you have read the policy document thoroughly and that the relevant cover exists under the policy.

You must be aware that any omission or misstatement on the forms may lead to the claim being declined. You or any other person completing the forms must do so as honestly and truthfully as possible. You must make sure that you provide as much details as possible when answering the questions. In the case of a deliberate omission or misstatement that may influence the outcome of the claim, a case of fraud may also be instituted against yourself or the person completing the form. You must also convey this to the doctor or employer when completing the forms.

You must ensure that you have enclosed copies of all relevant reports and documents, as failure to do so may delay the processing of the claim. Where we have requested copies of medical reports or laboratory and other results, it is your responsibility to ensure that these are forwarded to us. Once we have reviewed the claim we may request additional information. It is your responsibility to forward us that information as quickly as possible. No decision may be made on a claim if any requested information is outstanding.

Below we have illustrated a table of what forms must be completed. We have also indicated what other documents must be submitted with your claim. Please ensure that you submit completed and signed copies of all the forms requested, and all the documents required. Where unable to do so please advise us of the reason/s to enable us to assist, give further instructions / assistance.

Once we have received the initial claim documentation we will inform you of any further requirements or our decision. You must be aware that the completion of any forms and the submission of a claim in no way constitute an admission of liability on the insurer.

Kindly return personal statement within 30 days of notification and all other documents as soon as possible. We thank you for your assistance in this matter.

Forms Required	Type of Benefit	
	Temporary Disability	Permanent Disability
Declaration of Consent	X	X
Personal Statement by Claimant	X	X
Medical Report by Treating General Practitioner	X	X
Medical Report by Treating Specialist	X	X
Employers Declaration	X	X
Documents Required	**Temporary Disability**	**Permanent Disability**
Certified Copy of Identity Document (Claimant and Policy holder if not same person)	X	X
Sick Leave Records / Sick Notes	X	X
Job Description	X	X
Results of all special investigations Medical	X	X
Medical Aid Application	X	X
Medical Aid Records	X	X
If self – employed, letter from accountant of attorney	X	X
Hospital Admission / Discharge Form / Patient File	X	X
Accident report of motor vehicle accident	X	X
Alcohol and Drug test results	X	X
Comprehensive insurer details if Vehicle Accident.	X	X
Legal standing to claim if not policyholder. (E.G. Appointed Executor)	X	X

Finance Documents Required	Temporary Disability	Permanent Disability
Contract / Installment Sale / Lease Agreement	X	X
Detailed Statement	X	X
Amortisation / Repayment Schedule	X	X
Dealers Tax Invoice	X	X
Application for Finance	X	X

PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

Declaration of Consent

Policyholder's Personal Details

Name & Surname: _____

Date of Birth: D D M M Y Y ID No: _____

Policy No: _____

Medical Aid: _____ Medical Aid No: _____

To facilitate the assessment of the risk and the consideration of any claim for benefits, under the aforementioned policy I irrevocably authorize PinnAfrica to obtain from any person, institution or organization, any information which PinnAfrica deems necessary for the assessment of my claim.

I hereby authorize any medical practitioner, hospital, institution, pharmacy, my employer, my medical aid scheme or any other person who has any information of whatsoever nature relating to my health, to provide such information to an authorized representative of PinnAfrica who requires this information for the purposes of assessing my claim.

I hereby authorize PinnAfrica to release or disclose any medical information relating to my health and my claim to any party who may require such information for the purposes of assessing my claim for benefits.

I further indemnify the aforementioned party / parties and the insurer against any loss, damage or injury that I may incur in any manner whatsoever, directly or indirectly, as a result of disclosing such information

_____ _____

Policy Holder Signature Date

or

_____ _____

Duly Authorized Signatory / Next of Kin Date

_____ _____

Full Name of Authorised Signatory / Next of Kin Relationship to claimant

PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

EMPLOYER'S DECLARATION

Dear Employer,

Your employee is applying for insurance benefits against his/her policy, and in order to assess his/her claim we require your assistance by completing this questionnaire truthfully and to the best of your knowledge. The form must be completed by the employee's manager or an authorized signatory of the company. Please provide as much detail as you have available. Please ensure that you have enclosed a copy of the relevant Job Description, a salary slip and sick leave records or sick notes for the employee. Your employee is anxious to receive a response regarding his/her claim, please return the completed form to us at your earliest convenience.

Thank you for your assistance.

1. EMPLOYEE'S DETAILS

Employee's Name and Surname: _____

Date of Birth: d d m m y y

Policy Number: _____

ID Number: | | | | | | | | | | | | | |

Employee No: _____

Residential Address: _____

_____

Postal Address: _____

_____

Employee's Contact Details:

Home Tel: ( )	**Work Tel:** ( )
Fax: ( )	**Cell:**
E - Mail:	

Marital Status: _____

No of Dependants:_____

Medial Aid Scheme: _____

Medical Aid No:_____

2. EMPLOYMENT DETAILS

2.1. Name of Employer:_____

2.2. Contact No:_____ Contact Person:_____

2.3. Date of Employment: | d | d | m | m | y | y |

2.4. Type of employment:

Part – Time		**Full – Time**	
Contract		**Self – Employed**	

2.5. For what Occupation was she/he employed: _____

2.5.1. When was the last day she/he was able to perform this occupation: | d | d | m | m | y | y |

2.5.2. Please provide a description of the duties for this occupation:

_____

_____

** NOTE ** PLEASE ENCLOSE A COPY OF THE FULL JOB DESCRIPTION FOR THIS OCCUPATION

2.6. After she/he became ill / disabled was an alternate occupation or light duties given? | YES | NO |

2.6.1. What was the alternate occupation / light duties: _____

2.6.2. When did she/he start the alternate occupation / light duties : | d | d | m | m | y | y |

2.6.3 When was the last day she/he was able to perform the alternate occupation / light duties:
| d | d | m | m | y | y |

2.6.4. Please provide a description of the duties for the alternate occupation / light duties:

_____

_____

** NOTE ** PLEASE ENCLOSE A COPY OF THE JOB DESCRIPTION FOR THE ALTERNATE OCCUPATION OR LIGHT DUTIES

2.7. If an alternate occupation was offered, but she/he did not pursue that occupation, please state what job was offered and the employee's reasons for the decision.

_____

_____

2.8. If she/he was employed on a Part-time basis or over a Contract period, please state details:

_____

_____

2.9. What is his/her current work status:

Ill – Health Retirement		**Medically Boarded**		**Sick Leave**		**Resigned**	
Retrenched		**Still at Work**		**Other**			

2.9.1. Since when has this been his/her work status? d d m m y y

2.10. When is the employee expected to return to work? d d m m y y

2.11. What was the employee's normal monthly salary? _____

** NOTE ** PLEASE ENCLOSE A COPY OF THE EMPLOYEE'S SALARY SLIP

2.12. Is the employee receiving any form of income? YES | NO

2.12.1. Please state amount and the source? _____

2.13. Did the employee belong to a Pension or Provident Fund, or Risk Benefit scheme? YES | NO

2.13.1. Please state the type of Fund: _____

2.13.2. What is the name of the fund? _____

2.13.3. Who is the insurer or underwriter? _____

2.13.4. What is the employee's membership number? _____

2.13.5 Please describe the type of benefits available. E.g. Temporary or Permanent Disability etc.

_____

_____

2.13.6. Has the employee received any benefits? YES | NO

2.13.6.1. What benefit has been received? Temporary / Permanent Disability etc.

_____

2.13.6..2. Since when has the employee been in receipt of the benefit? d d m m y y

2.13.6.3. Please state when the benefit expected to stop and why:

_____

_____

_____

2.14. Please provide details of the employee's sick leave record for the previous 3 years;

** NOTE ** PLEASE ENCLOSE COPIES OF ANY SICK NOTES AND RECORDS AVAILABLE

From						To						Number of Working days	Reason / Illness / Injury
d	d	m	m	y	y	d	d	m	m	y	y		
d	d	m	m	y	y	d	d	m	m	y	y		
d	d	m	m	y	y	d	d	m	m	y	y		
d	d	m	m	y	y	d	d	m	m	y	y		
d	d	m	m	y	y	d	d	m	m	y	y		

3. DETAILS OF ILLNESS / DISABLEMENT

3.1. Please provide a description of the symptoms / impairments that prevent the employee from working:

_____

_____

_____

3.2. When did the signs and symptoms first become noticeable? | d | d | m | m | y | y |

3.3. If the illness / disability is due to an injury or trauma, please state the date that it occurred and provide a brief description of the incident: to the best of your knowledge:

_____

_____

_____

3.4. If the condition is due to an Injury On Duty (IOD) please state whether the employee has received any compensation, the amount of the benefit, the claim number, where the employee was treated, the date of the incident and briefly describe the event:

_____

_____

_____

_____

3.5. Please provide any other information related to the employee's employment history with the company and to his/her health that may be relevant to this claim:

_____

_____

4. D E C L A R A T I O N

I hereby declare that to the best of my knowledge the above answers are true and correct, and that no material information has been withheld or omitted.

Name: _____ Position: _____

Company Stamp:

Signature:_____ Date: | d | d | m | m | y | y |

PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

MEDICAL REPORT
BY TREATING GENERAL PRACTITIONER

Dear Doctor,

Your patient is applying for insurance benefits against his/her policy, and in order to assess his/her claim we require your assistance in providing us with the relevant medical information relating to his/her condition. Please complete the questions below truthfully and to the best of your knowledge, providing as much detail as possible. Copies of all special tests and investigations performed must be attached and forwarded together with this form. Your patient is anxious to receive a response regarding his/her claim, please return the completed form to us at your earliest convenience.

Thank you for your assistance.

1. MEDICAL PRACTITIONER'S DETAILS

Name of Doctor: _____ Practice Number: _____

Postal Address: _____

Telephone Number: _____ Facsimile Number: _____

E-mail Address: _____ Qualifications: _____

Since which date have you been the claimant's treating General Practitioner: d d m m y y

In your opinion when was the last day she/he was actively able to work: d d m m y y

2. CLAIMANT'S PERSONAL DETAILS

Claimant's Name and Surname: _____

Date of Birth: d d m m y y Policy Number: _____

ID Number: | | | | | | | | | | | | | Form of Identification: _____

Occupation: _____ Last day at work: _____

3. CLAIMANT'S MEDICAL HISTORY

3.1. Please provide a full clinical history in relation to the condition for which your patient is claiming, including the following:

- Symptoms, diagnoses, and dates of all diagnoses
- Clinical details indicating the severity, extent and permanence of the patient's condition
- Please enclose relevant test results (e.g. blood results, CD4 count, HIV results, lung function readings, histology reports, X-ray or scan results)
- Treatment, compliance and response

_____

_____

_____

_____

_____

_____

3.2 Is the claimant's current condition related to;

a) Previous illness or injury | YES | NO |

b) Substance abuse behaviour or disorders of any type | YES | NO |

c) Attempted suicide or self inflicted injury | YES | NO |

d) The use of tobacco products, alcohol or narcotics | YES | NO |

3.2.1 If the answer to any of the above is yes please provide full details:

_____

_____

_____

4. CONSULTATION HISTORY

4.1 Date that your patient first presented with symptoms related to the condition for which she/he is currently claiming | d | d | m | m | y | y |

4.2 Date of your last consultation in relation to the current condition: | d | d | m | m | y | y |

4.3 Please provide details of all other consultations at your practice, whether or not the reason for consultation was related to the condition currently being claimed for:

Date	Reason for Consultation	Diagnosis	Treatment

Should you require additional space please continue on a separate sheet

5. MOST RECENT CONSULTATION

5.1 Date of most recent examination: | d | d | m | m | y | y |

5.2 Please provide full clinical details of the claimant's presentation as at the most recent consultation, including all your findings during the observation and examination. Please include details of any limitations evident at that examination (e.g. joint limitations, visual acuity etc)

_____

_____

_____

_____

_____

_____

_____

_____

6. PROGNOSIS

6.1 In your opinion, what is the claimant's prognosis | GOOD | FAIR | POOR | NIL |

6.2 Will she/he be able to resume his/her occupation in the future | YES | NO |

6.2.1. If yes, when do you envisage that he/she will return to work. | d | d | m | m | y | y |

7. MEDICAL REFERENCES

7.1 Please provide the details of any other Practitioners, Specialists or Hospitals to whom the Claimant has been referred, either in relation to the condition being claimed for or for any other condition. Please include copies of all available Specialist reports.

Name of Practitioner / Hospital			
Specialty			
Contact Number			
Patient / File Number			
Address			
Complaints Referred for			

8. FUNCTIONAL ABILITY

8.1 Please comment on the claimant's ability to engage in the tasks listed in the table below

ACTIVITY	Current Limitations			Expected Future Abilities		
	None	Partial	Impossible	Improve	Remain Constant	Deteriorate
Seated/sedentary tasks						
Clerical/administrative tasks						
Thinking clearly & making decisions						
Interacting with others						
Supervising others						
Walking (non-strenuous) over level ground						
Walking (strenuous) over uneven ground						
Climbing						
Kneeling						
Standing						
Bending						
Operating light machinery						
Operating heavy machinery						
Working with heavy weights						
Working with light weights						
Driving a light motor vehicle						
Light manual labour						
Heavy manual labour						
Use both hands						
Use of fine coordination						
Work in cramped conditions						
Work in dusty environments						
Work in a fume environment						

9. ADDITIONAL INFORMATION

9.1. Is there any other information which in your opinion may assist us in assessing this claim:

_____

_____

_____

_____

_____

10. D E C L A R A T I O N

I hereby declare that I have personally examined ad attended to the claimant and that the content of this report is true and correct, and that no information which may influence the outcome of this claim has been withheld.

Doctor's Signature:_____ Date: d d m m y y

PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

MEDICAL REPORT
BY TREATING SPECIALIST

Dear Doctor,

Your patient is applying for insurance benefits against his/her policy, and in order to assess his/her claim we require your assistance in providing us with the relevant medical information relating to his/her condition. Please complete the questions below truthfully and to the best of your knowledge, providing as much detail as possible. Copies of all special tests and investigations performed must be attached and forwarded together with this form. Your patient is anxious to receive a response regarding his/her claim, please return the completed form to us at your earliest convenience.

Thank you for your assistance.

1. MEDICAL PRACTITIONER'S DETAILS

Name of Doctor: _____ Practice Number: _____

Postal Address: _____

Telephone Number: _____ Facsimile Number: _____

E-mail Address: _____ Qualifications: _____

Area of specialty: _____

By whom was the patient referred: _____

Since which date have you been the claimant's treating Specialist:

d	d	m	m	y	y

In your opinion when was the last day she/he was actively able to work:

d	d	m	m	y	y

2. CLAIMANT'S PERSONAL DETAILS

Claimant's Name and Surname: _____

Date of Birth: | d | d | m | m | y | y | Policy Number: _____

ID Number: | | | | | | | | | | | | | Form of Identification: _____

Occupation: _____ Last day at work: _____

3. CLAIMANT'S MEDICAL HISTORY

3.1. Please provide a full clinical history in relation to the condition for which your patient is claiming, including the following:

- Symptoms, diagnoses, and dates of all diagnoses
- Clinical details indicating the severity, extent and permanence of the patient's condition
- Please enclose relevant test results (e.g. CD4 count, HIV results, lung function readings, histology reports, X-ray or scan results)
- Treatment, compliance and response

_____

_____

_____

_____

_____

_____

_____

3.2 Is the claimant's current condition related to;

a) Previous illness or injury | YES | NO |

b) Substance abuse behaviour or disorders of any type | YES | NO |

c) Attempted suicide or self inflicted injury | YES | NO |

d) The use of tobacco products, alcohol or narcotics | YES | NO |

3.2.1 If the answer to any of the above is yes please provide full details:

_____

_____

_____

4. CONSULTATION HISTORY

4.1 Date that your patient first presented with symptoms related to the condition for which she/he is currently claiming

d	d	m	m	y	y

4.2 Date of your last consultation in relation to the current condition:

d	d	m	m	y	y

4.3 Please provide details of all other consultations at your practice, whether or not the reason for consultation was related to the condition currently being claimed for:

Date	Reason for Consultation	Diagnosis	Treatment

Should you require additional space please continue on a blank sheet

5. MOST RECENT CONSULTATION

5.1 Date of most recent examination:

d	d	m	m	y	y

5.2 Please provide full clinical details of the claimant's presentation as at the most recent consultation, including all your findings during the observation and examination. Please include details of any limitations evident at that examination (e.g. joint limitations, visual acuity etc)

_____

_____

_____

_____

_____

_____

_____

6. PROGNOSIS

6.1 In your opinion, what is the claimant's prognosis

GOOD	FAIR	POOR	NIL

6.2 Will she/he be able to resume his/her occupation in the future

YES	NO

6.2.1. If yes, when do you envisage that he/she will return to work.

d	d	m	m	y	y

7. MEDICAL REFERENCES

7.1 Please provide the details of any other Practitioners, Specialists or Hospitals to whom the Claimant has been referred, either in relation to the condition being claimed for or for any other condition. Please include copies of all available reports.

Name of Practitioner / Hospital			
Specialty			
Contact Number			
Patient / File Number			
Address			
Complaints referred to			

8. FUNCTIONAL ABILITY

8.1 Please comment on the claimant's ability to engage in the tasks listed in the table below

Activity	Current Limitations			Expected Future Ability		
	None	Partial	Impossible	Improve	Remain Constant	Deteriorate
Seated/sedentary tasks						
Clerical/administrative tasks						
Thinking clearly & making decisions						
Interacting with others						
Supervising other						
Walking (non-strenuous) over level ground						
Walking (strenuous) over uneven ground						
Climbing						
Kneeling						
Standing						
Bending						
Operating light machinery						
Operating heavy machinery						
Working with heavy weights						
Working with light weights						
Driving a light motor vehicle						
Light manual labour						
Heavy manual labour						
Use both hands						
Use of fine coordination						
Work in cramped conditions						
Work in dusty environments						
Work in a fume environment						

9. ADDITIONAL INFORMATION

9.1. Is there any other information which in your opinion may assist us in assessing this claim:

_____

_____

_____

10. D E C L A R A T I O N

I hereby declare that I have personally examined and attended to the claimant and that the content of this report is true and correct, and that no information which may influence the outcome of this claim has been withheld.

Doctor's Signature:_____ Date: d d m m y y

** NOTE** IF YOUR PATIENT IS APPLYING FOR A CRITICAL ILLNESS BENEFIT, IN ADDITION TO COMPLETING THIS FORM YOU ARE REQUIRED TO SUBMIT A BRIEF REPORT ACCORDING TO THE GUIDELINES STIPULATED IN THE FORM MARKED 'GUIDELINES FOR CRITICAL ILLNESS REPORT'. PLEASE CHECK WITH YOUR PATIENT AS TO THE TYPE OF CLAIM SHE/HE IS MAKING.

PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

PERSONAL STATEMENT BY CLAIMANT

Dear Claimant,

If you are making a claim for a Total and Permanent Disability Benefit, or, a Temporary Disability Benefit, you are required to complete this form as truthfully and in as much detail as possible. The form must be completed and signed by the person making the claim. Before you complete this form you must ensure that you have thoroughly read the document marked "Directions to Claimant". Any misstatement in this form may be used as grounds for the claim not being admitted. You must be sure to attach copies of all medical reports, including results of blood tests, x-rays, histology and laboratory reports. Failure to enclose these reports may result in a delay in your claim. You must be aware that completing this form in no way constitutes an admission of liability on the insurer.

1. YOUR DETAILS

Name and Surname: Mrs / Ms /Mr /Dr /Prof _____

Date of Birth: D D M M Y Y Policy No.: _____

ID Number: | | | | | | | | | | | | | |

Residential Address: _____

_____

Postal Address: _____

_____

Your Contact Details:

Home Tel: ( )	**Work Tel:** ( )
Fax: ( )	**Cell:**
E – Mail:	

Marital Status: _____ No of Dependants:_____

Medial Aid Scheme: _____ Medical Aid No:_____

2. EMPLOYMENT DETAILS

2.1. Name of Employer:_____ Contact No:_____

2.2. Date of Employment: | D | D | M | M | Y | Y |

2.3. Type of employment:

Part – Time		**Full – Time**	
Contract		**Self – Employed**	

2.4. For what Occupation were you employed: _____

2.4.1. When was the last day you were able to perform this ccupation: | D | D | M | M | Y | Y |

2.4.2. Please provide a description of the duties for this occupation:

_____

_____

2.5. After you became ill / disabled did you perform an alternate occupation or light duties ? | YES | NO |

2.5.1. What was the alternate occupation / light duties: _____

2.5.2. When did you start the alternate occupation / light duties : | D | D | M | M | Y | Y |

2.5.3 When was the last day you were able to perform the alternate occupation / light duties:

| D | D | M | M | Y | Y |

2.5.4. Please provide a description of the duties for your alternate occupation / light duties:

_____

_____

2.6. If your employer offered you an alternate occupation, but you did not pursue that occupation, please state what job was offered to you and the reasons for your decision.

_____

_____

2.7. If you were employed on a Part-time basis or over a Contract period, please state details:

_____

_____

2.8. If you were self-employed, please provide details as to the current status of your business, by whom it is now being managed /run, and your current level of involvement in the business:

_____

_____

2.9. What is your current work status:

Ill – Health Retirement		**Medically Boarded**		**Sick Leave**		**Resigned**	
Retrenched		**Still at Work**		**Other**			

2.9.1 Since when has this been your work status? | D | D | M | M | Y | Y |

2.10. Do you intend to resume work in the future, and if so when ? | YES | NO | | D | D | M | M | Y | Y |

3. EDUCATIONAL & WORK HISTORY

3.1. What is your highest level of school education? _____

3.2. What are your other academic, professional or trade qualifications?

_____

_____

3.3. Please provide details of your work history for the last 10 years

Employer	Occupation	Start Date	End Date	Reason for leaving

4. DETAILS OF YOUR ILLNESS OR DISABILITY

** NOTE ** YOU MUST ENCLOSE COPIES OF ALL MEDICAL REPORTS, AND COPIES OF ALL TEST RESULTS RELATING TO YOUR HEALTH AND YOUR CLAIM.

4.1. What illness / injury or impairment prevents you from performing your occupation?

_____

_____

4.2. When was the condition diagnosed? D D M M Y Y

4.3. Please provide the name and contact details for the doctor who made the diagnosis?

_____

_____

4.4. When did you first start to experience sings and symptoms related to the condition? D D M M Y Y

4.5. When did you first consult a doctor for the condition, or for symptoms related to the condition, and which doctor did you consult?

_____

_____

4.6. If your condition is due to an accident or trauma, please state the date of the event and briefly describe the incident, including the hospital or doctor who treated you

_____

_____

_____

_____

4.7. Describe the symptoms and impairments that prevent you from performing your occupation

_____

_____

_____

_____

4.8. Please provide the name and contact details for your usual family doctor for the last five years:

_____

_____

4.9. Please provide the name and contact details for the Specialist/s who is/are currently treating you for the condition

_____

_____

4.10. State the names and dosages of all medications that you are currently using

_____

_____

_____

4.11. Do you require any assistance to move around or walk. If yes please provide details

_____

_____

4.12. Please provide a history of all the medical consultations you have had over the last five years (influenza may be omitted). Should you require additional space please continue on a separate sheet.

Date	Complaint/s	Doctor / Hospital	Contact Number	Tests Done	Treatment Prescribed

4.13. Briefly describe the activities that currently occupy your day

_____

_____

_____

_____

_____

5. DETAILS ABOUT YOUR INCOME

5.1. What was your monthly income before you became ill or disabled? R_____

5.2. Have you received any income since becoming ill or disabled? | YES | NO |

5.2.1 If yes, please state the amount and the source of the income

_____

5.3. If you have received, or are expecting to receive any other income or insurance benefit, please state the source, the amount, and the date that payment is expected.

_____

_____

6. D E C L A R A T I O N

DECLARATION

I hereby declare that I am the policy holder and that all the particulars given on this claim form are to the best of my knowledge true and correct, and that no material information has been withheld or omitted.

I hereby authorise any medical practitioner, hospital or any other person who has information about my health to provide such information to Pinnafrica or any party nominated by Pinnafrica who requires this information for the purposes of assessing my claim. I acknowledge that I understand the confidential nature of medical information, and I agree that any such disclosures shall in no way be seen as a breach of my rights to privacy and confidentiality.

I hereby authorise Pinnafrica to furnish any medical information contained in medical reports or otherwise which they have obtained during the course of the assessment of my claim to any medical or allied medical practitioner who may require such information for the purposes of assessing of my claim

_____ | D | D | M | M | Y | Y |

CLAIMANT'S SIGNATURE **DATE SIGNED**