MyLife

Disability Claim Form

Hollard. life

(To be completed by medical attendant)

Please note that it is essential to complete this form in full to prevent unnecessary delays as a result of missing information.
Please note that should there be any charges for the completion of this form, such charges will be for the life insured's account.

The following must be included when submitting this form:
To assess the claimant's degree of impairment (medical assessment), and to ascertain:

a. Diagnosis
b. Alteration(s) of functional capacity due to illness or injury
c. Optimal medical treatment

Return the completed form and the above documents to LifeClaims2@hollardnam.com

1. Life assured details

Policy no. _____ ID no. _____

Name of insured _____

Policy owner _____

Employer _____ Occupation _____

1.1. Date of first consultation D D M M Y Y Y Y

1.2. Date of last consultation D D M M Y Y Y Y

1.3. Date of diagnosis of the claimant's illness D D M M Y Y Y Y

1.4. What was the diagnosis of the claimant's condition? _____

1.5. What were the symptoms? _____

1.6. When did the first symptoms of the condition appear? D D M M Y Y Y Y

1.7. What has caused the disability?

1.8. What are the resultant limitations experienced?

1.9. Provide details of any complications or concurrent conditions

1.10. Are you still attending to the claimant? ☐ Yes ☐ No

1.11. Does the claimant have insight into his/her illness? ☐ Yes ☐ No

1.12. Provide details of all consultations in the last 5 years

Date	Reason for consultation	Diagnosis	Treatment	Outcome

1.13. Has the claimant ever been hospitalised? ☐ Yes ☐ No

Provide details of hospitalisation

Date from	To	Reason for hospitalisation	Hospital/Doctor	Treatment	Outcome

1.14. Has the claimant been referred to any health care professionals, e.g. physiotherapists, occupational therapists, psychologists, or other medical specialists? ☐ Yes ☐ No

Provide details

Name	Designation	From	To	Treatment	Outcome

1.15. Have any of the following contributed in any way to the claimant's disablement?

Nature of contributor, and give details

Previous illness or injury ☐ Yes ☐ No _____

Hazardous pursuit or pastime ☐ Yes ☐ No _____

Habits (e.g. excessive alcohol consumption, smoking) ☐ Yes ☐ No _____

Self-inflicted injuries ☐ Yes ☐ No _____

1.16. How has the patient's condition been treated?

Date	Therapy/Medication	Description/Dosage

Describe fully, in detail

Strict compliance by claimant with medication/therapy ☐ Yes ☐ No _____

Is the condition satisfactorily controlled? ☐ Yes ☐ No _____

Is the claimant undergoing optimal therapy? ☐ Yes ☐ No _____

Is future surgery planned/required/anticipated? ☐ Yes ☐ No _____

If so, when? D D M M Y Y Y Y

Any additional comments

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

2. 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 200 m on level surfaces	☐ Can	☐ With help	☐ Cannot
Transferring	The ability to move from a bed to an upright chair or wheelchair and vice 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 to get food and/or drink to the mouth	☐ Can	☐ With help	☐ Cannot
Toileting	The ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances, if appropriate. This includes the maintenance of continence	☐ 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 and lifting	The ability to get into and out of a standard size car, bend, kneel or pick up something from the floor, lift, carry or move everyday objects	☐ Can	☐ With help	☐ Cannot
Co-ordination	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

2.1. In your opinion, at which date was the claimant last able to work? D D M M Y Y Y Y

2.2. When is the claimant expected to return to work? D D M M Y Y Y Y

2.3. 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 D D M M Y Y Y Y

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

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

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.

3. Notice to medical attendants

Practice no. _____ Qualifications _____

Tel. no. _____ Fax no. _____

Full name _____

E-mail address _____ Mandatory

Postal address _____

4. Declaration by medical attendant

I declare that I have personally attended to the patient and that the statements above are true and complete.

Signature _____ **Date** D D M M Y Y Y Y