FAMILY RESPONSIBILITY RIDER BENEFIT – DEATH CLAIM (DECLARATION BY DOCTOR)

FOR PROFESSIONALS
SINCE 1941

NOTE *To be completed by the treating Medical Attendant only.*

Please answer all the questions in full to ensure a timeous and complete assessment of your client's claim.

PPS obtained prior written consent from the life insured in terms whereof additional information pertaining to the claim may be provided.
PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your patient's personal information.
PPS will adhere to any laws governing the protection of (and access to) personal information; and will not use the information for any purpose not provided for in the PPS Policy Contract.

Please return the fully completed form to PPS Claims Fax: 011 644 4520 or email to claims@pps.co.za

PART A: MEMBER DETAILS

Member number:

Initials: Surname:

Date of birth: D D / M M / Y Y Y Y

Email:

Cellular: 0

PART B: DETAILS OF THE CLAIM

Particulars of the patient

Name:

Surname:

National ID number/Passport if no ID:

PART C: MEDICAL CONDITION

1. Cause of death:
2. Contributory causes of death (if applicable):
3. Date of death: D D / M M / Y Y Y Y
4. Provide **date of initial consultation** and brief details of the **chronological history** of the condition, resulting in the death, or sequence of events:

5. Treatment or investigations conducted in respect of cause of death and contributory cause(s) of death:
   NOTE Please attach copies of all relevant investigations conducted.

Date	Details	Doctor

PART D: MEDICAL PRACTITIONER'S DETAILS

HPCSA Reg No: | | | | | | | | | | | Practice No: | | | | | | | | | | |

Surname: Initials:

Telephone No: Fax No:

Email Address:

Address:

Signed at this day of 20

Signature of Medical Attendant