$-"*. '03 4*$,/&44 #&/&'*5 %&$-"3"5*0/ #: .&.#&3 '03 $-"*. 3&
$07*% $030/"7*364 */'&$5*0/

7KH 3URIHVVLRQDO 3URYLGHQW 6RFLHW\ +ROGLQJV 7UXVW 1R ,7 336 LV D 5HJLVWHUHG 6
3URYLGHQW 6RFLHW\ ,QVXUDQFH &RPSDQ\ /LPLWHG 5HJ 1R 3URIHVVLRQDO 3URYLGHQW
/LPLWHG LV D OLFHQVHG LQVXUHU FRQGXFWLQJ OLIH LQVXUDQFH EXVLQHVV DQG DXWKRULVHG ILQDQFLDO
VHUYLFHV SURYLGHU

,03257$17

$OO PHGLFDO LQIRUPDWLRQ ZLOO EH WUHDWHG DFFRUGLQJ WR
6RXWK $IULFD $6,6$ JXLGHOLQHV UHODWLQJ WR FRQILGHQWLDOLW\ RI
$Q\ FRVWV LQFXUUHG LQ REWDLQLQJ WKH VXSSRUWLQJ GRFX

336 &ODLPV &RQWDFW GHWDLOV

H PDLO FODLPV#SSV FR]D
)D[
4XHULHV
H PDLO PHPEHUVHUYLFHV#SSV FR]D
7HO

&29,' 5HODWHG 6LFN /HDYH &ODLP 5HTXLUHPHQ		
7RSLF		5HTXLUHPHQWV DQG QRWHV
$	$OO W\SHV &29,' FODLPV	x R &RS\ &29,' WHVW UHVXOW x 'HFODUDWLRQ E\ PHPEHU x 'HFODUDWLRQ E\ PHPEHU 336 ,QVXUDQFH DOVR UHVHUYHV WKH ULJKW WR FODLP DQ\ VSHFLILF PHGLFDO HYLGHQFH WKDW LW GHHPV UHOHYDQW WR SURFHVV DQG DOORZ WKH FODLP
%	&ODLP GXUDWLRQ	
	GD\V RU OHVV QRWH DERYH	0RVW SHRSOH ZKR FRQWUDFW &29,' GHYHORS PLOG V\PSWRPV DQG ZLOO EH DEOH WR ZRUN IURP KRPH RU UHWXUQ WR ZRUN ZLWKLQ GD\V V\PSWRPV UHVROYH...
	([FHHGLQJ GD\V	x ,Q DGGLWLRQ WR $ DERYH PHGLFDO UHSRUWV DQG VSHFLDO LQYHVWLJDWLRQV XQGHUWDNHQ x $Q\ RWKHU UHOHYDQW GRFXPHQWV 5HIHU WR WKH DGGHQGXP DWWDFKHG WR WKH 'HFODUDWLRQ E\ 'R UHTXLUHPHQWV WR VXEVWDQWLDWH H[WHQGHG FODLPV
&	&29,' FRPSOLFDWLRQV	x $GGLWLRQDO PHGLFDO UHSRUWV ... UHOHYDQW PHGLFDO LQYHVWLJDWLRQV x $Q\ RWKHU UHOHYDQW GRFXPHQWV ... H[WHQGHG UHFRYHU\ 5HIHU WR WKH DGGHQGXP DWWDFKHG WR WKH 'HFODUDWLRQ E\ 'R UHTXLUHPHQWV WR VXEVWDQWLDWH H[WHQGHG FODLPV
'	/RQJ &29,'	x %H\RQG WKH LQLWLDO ... UHFRYHU\ ... x &ODLPV ... DVVHVVHG UHWURVSHFWLYHO\

PART A: MEMBER DETAILS

O o t o t | | | | | | | | | Fc h D t D M M Y Y Y Y

Surname: Initials:

National ID number : Cellular:

Medical aid name: Medical aid number:

Email address :

PART B: PARTICULARS OF CLAIM

1.1 Provide **details of the disease/condition** that **significantly prevented you** from performing your **usual professional duties** and **required optimal medical treatment or supervision** such as: medication, hospitalisation, surgery or rehabilitation.

1.2 Date of onset of disease/condition: D D M M Y Y Y Y

1.3 Describe the **symptoms of the disease/condition** and **how it affected** your **ability to perform** your usual **professional duties**:

1.4 Date symptom/s of the disease/condition ended: D D M M Y Y Y Y

1.5 Testing for COVID-19:

Have you been tested for COVID-19? YES NO

Date or sample collection	**Type of test e.g. PCR or Antibody test, rapid antigen test**	**Result**	**Result Date**

1.6 Describe the **complications experienced** and **how it influenced** your **ability to** perform your **professional duties (where applicable)**.

2. Did the illness originate outside a Southern African Development Community (SADC) country? YES ☐ NO ☐

If YES, specify country: _____

3. Details of hospitalisation and rehabilitation

3.1 **Hospitalisation**

Did you require admission to hospital? YES ☐ NO ☐

Name of hospital:

Attach a copy of the admission sheet or the hospital account showing admission and discharge dates if you were hospitalised for at least four consecutive days and wish to claim against your Admission Rider Benefit (if applicable).

3.2 **Rehabilitation**

Studies have shown that **early intervention** with rehabilitation, e.g. physiotherapy, occupational therapy, counselling or biokinetics has **yielded positive results.**

Describe the measure/management you and your specialist have undertaken/ are undertaking to improve your symptoms:

Date rehabilitation commenced: D D M M Y Y Y Y

rehabilitation stopped: D D M M Y Y Y Y

If rehabilitation was stopped, kindly provide reasons:

4. Please state the name(s) of the doctor(s) and allied medical practitioners who attended to you, in respect of this claim. It may be necessary for our claims area to contact them for further information.

Practitioner's Surname and Initials	**Consultation Date/s**	**Tel**	**E-mail**

5. Claim dates:

TOTAL BENEFITS:

I was **NOT** able to perform **ANY** professional duties:

From: D D M M Y Y Y Y To: D D M M Y Y Y Y

PARTIAL BENEFITS:

I was able to perform some of my work duties while recuperating at home; or worked for a limited period per day.

From: D D M M Y Y Y Y To: D D M M Y Y Y Y

DATE OF RETURN TO WORK:

On a Partial basis D D M M Y Y Y Y On a Full-time basis: D D M M Y Y Y Y

Provide **details of the duties** that you were **able to perform remotely**, focusing on the nature of the duties performed and time spend performing these duties, e.g. administrative work, virtual consultations, etc.:

PART C: EMPLOYMENT QUESTIONS RELATED TO THE WORK PERFORMED DIRECTLY PRIOR TO CLAIM.

8 Please state the following regarding your occupation:

DD Current Occupation:

D Commencement date of occupation: D D M M Y Y Y Y

F

Question	**YES**	**NO**
Are you a healthcare worker?		
Are you self-employed?		
Are you able to work remotely?		

d) Describe the nature of your usual professional duties:

7. ONLY COMPLETE if Self-employed:

State the name of your practice/business:

Gross Professional Income (Annual income from professional fees and nett income from trading activities):

(Minus) Actual Expenses (Expenses incurred in the running of the business that are not remunerated to the professional. Expenses that will terminate if the business is sold or closed):

(Equals) Personal Income (Gross Professional Income minus Actual Expenses):

8. ONLY COMPLETE if in Salaried employment

State the name of your employer:

State your annual income as:

Annual Total Cost to Company
(Annual salary plus all fringe benefits):

(Plus) Performance Bonus (Average over the last 3 years):

(Equals) Total Gross Professional income):

PART D: BANKING DETAILS FOR SICKNESS BENEFIT VIA EFT

NOTE: Only complete when payment is to be made into a bank account other than from which premiums are collected:
(Please attach a cancelled cheque or bank statement stamped by the bank).

Name of account holder:

Name of bank:

Account number:

Branch code:

Type of account: Current ☐ Savings ☐ Cheque ☐ Transmission ☐

PART E: DECLARATION

I specifically authorise PPS Insurance to communicate any requirements to my financial adviser which may entail providing information regarding my current medical condition ☐ YES ☐ NO

Financial Adviser's Name:

Financial Adviser's Email

I authorise PPS Insurance to:

a) Access any information which it deems necessary to assess any insurance risk or to consider a claim and I understand that if I choose not to provide this information PPS will not be able to assess my claim for insurance.

b) Share with other insurers and their representation body any information in the possession of PPS Insurance, either directly or through a database operated by, or for insurers as a group and authorise PPS to also collect my personal information from other insurers as exchange of information helps to wave costs and combat fraud. PPS can further process any such information in accordance or compatible with the purpose for which it was collected.

c) Disclose any information to the PPS Holdings Trust, subsidiaries, affiliates, Profmed or other persons provided that it is necessary to properly underwrite, manage, assess the claim or service the policy, policy assets or myself. PPS Insurance may be required to disclose your information to regulatory or government agencies.

d) Obtain credit information from any person or institution.

AND

I understand that I can request details of the information held by my insurer and request its correction where appropriate

AND

I authorise a doctor, hospital, medical aid or any other person to provide this information to PPS.

PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS will adhere to any laws governing the protection of (and access to) personal information; and will not use your information for any purpose not provided for in your Policy Contract and in this Part E.

Signed at (Place): on this day of 20

Signature of member: