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Credit Insurance Disability Confidential Medical Report

Treating specialist to complete this form.

Dear Doctor

The medical information requested in this form is in support of a claim for disability benefits. Your expertise and advice will provide a vital link in the process of assessing the claim.

Since this is an extremely stressful time for the claimant, we would appreciate your speedy assistance with this matter. Completing this form thoroughly will enable us to finalise the claim without unnecessary delays.

This report is in support of a claim application, therefore any cost in connection with this report will be for the account of the policyholder. Guardrisk and/or Capitec Bank will not be liable for any cost in connection with completing this report.

Please ensure that copies of all clinical/diagnositic test results and specialist reports, etc. are attached to this form.

Completed forms together with supporting documents must be emailed to CreditInsuranceClaims@capitecbank.co.za or faxed to 0860 11 11 43 for the attention of Disability Claims.

Section 1: Policyholder Details

Title Initials Date of Birth (D D M M Y Y Y Y)

First Name(s)

Surname

RSA ID No. Yes ☐ No ☐ ID/Passport Number

Passport Country of Origin Gender: Male ☐ Female ☐

Section 2: Medical Practitioner Details

Name of Doctor

Qualifications/Speciality

Hospital/Practice Name

Practice Number

HPCSA MP Number

Address

Postal Code

Telephone Number Fax Number

Email Address

Section 2: Medical Practitioner Details (continued)

Date of your first ever consultation with the member: D D M M Y Y Y Y

Date of your first consultation with regard to the current symptomology: D D M M Y Y Y Y

Date of your last consultation with the member (prior to current consultation): D D M M Y Y Y Y

Date of current consultation and examination: D D M M Y Y Y Y

How frequently do you see the member, e.g., once a month?

Section 3: Consultation History

Please give the details of any other practitioners, specialists or hospitals that the member has been referred to:

Name of Practitioner/Hospital

Speciality

Postal Address

Postal Code

Telephone Number(s)

Date referred D D M M Y Y Y Y

Complaints Referred For

Section 4: Medical References

Provide details of the illnesses/accidents for which you have attended since the member was referred to you:

Diagnosis	**Date of Consultation**
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

Provide a brief history of the claimant's condition:

Provide details of any current or previous substance abuse, if applicable:

Section 4: Medical References (continue)

Results of current medical examination:

Dominance (R/L)

Height (without shoes) Weight

Blood pressure (To be taken in recumbent posture. Exact reading to be given): Systolic mm.Hg

Diastolic mm.Hg

If the BP is 140/90 or higher, please record a second reading, preferably at the end of the examination: Systolic mm.Hg

Diastolic mm.Hg

Corrected visual acuity:

Limitations evident at the examination, e.g., range of movement, mental state:

Section 5: Details of Medical Condition

Current major complaint(s) as per the member:

Describe in full, the claimant's current symptoms:

Describe in detail the nature and extent of the member's impairment:

What are the clinical details indicating severity and permanence?

Provide the outcome of any other specialist consultations, if applicable. Enclose copies of available specialist medical reports:

Section 5: Details of Medical Condition (continue)

Provide dates and outcomes of any tests/investigations done to diagnose/quantify the member's condition. Enclose copies of any reports/investigations done:

Describe the previous and current pharmacological treatment that the member has/is receiving for their condition. Include names, dosage and dates/duration of all medication:

Provide details of any previous and current adjuvant therapy, e.g., physiotherapy, psychotherapy. Indicate dates, frequency and duration of any additional therapy received:

Provide details of any previous or current hospital admission, indicating the dates of admission, discharge and reason for admission:

Comment on any occupational therapy assessments, functional assessments or vocational rehabilitation received and the outcome thereof:

Comment on the effectiveness of treatment and the member's response to the treatment:

Advise what the planned future treatment is. Include medication, surgery, rehabilitation, etc., and provide dates:

In your opinion, is the condition one that would benefit from any form of active rehabilition? If **Yes**, provide suggestions/details of rehabilitation that would be beneficial:

Section 5: Details of Medical Condition (continue)

In your opinion is the treatment **optimal**? If **No**, suggest possible alternative therapy, medication, rehabilitation or surgery that may be attempted to maximise management:

Comment on the member's compliance with treatment (medication, therapy/rehabilitation, follow-up consultations, etc.). If they are not compliant, please provide the reason:

Has the condition stablised or regressed since its onset? Please provide substantiating details:

Please provide the member's short-term and long-term prognosis with supporting details:

In your experience, could you provide an indication of the expected recovery period necessary for this member and their condition?

Are there likely to be any residual problems? If **Yes**, provide the details:

Provide brief details of the claimant's current occupation (job title and duties):

In your opinion, what was the last date that the member was last actively able to work?

D D M M Y Y Y Y

Specify why, in your opinion, the member is finding it difficult to perform their current occupation and which specific functions of their occupation they cannot peform:

Section 5: Details of Medical Condition (continue)

What functions can the member still perform?

When is the member expected to be able to return to work?

D D M M Y Y Y Y

Has the claimant made any requests for or been offered reasonable accommodation at work? Provide the details:

For psychiatric claims complete the following questions.

Provide the DMA IV 5 axis diagnosis:

Axis I

Axis II

Axis III

Axis IV

Axis V

Provide details and comment on any family history of mental illness:

Provide the clinical examination/mental state examination findings. Record general appearance mood, anxiety, phychotic features, mental state, cognitive and social functioning etc.:

Provide the results of any bedside cognitive assessments, e.g., but not limited to MMSE:

Section 5: Details of Medical Condition (continue)

Comment on the member's current and expected future ability to carry out the specified activities in the table below:

Activity	Current Limitations				Expect Future Ability		
	No Limitations	Partial Limitations	Impossible	Danger to Self and Others	Improve	Remains Constant	Deteriorate
Seated/Sedentary tasks							
Clerical/Admin tasks							
Thinking clearly and making decisions							
Interacting with others							
Supervising others							
Walking on level ground							
Walking on uneven terrain							
Climbing							
Kneeling							
Standing							
Bending							
Operating light machinery							
Operating heavy machinery							
Working with light weights							
Working with heavy weights							
Driving a light motor vehicle							
Driving a heavy motor vehicle							
Light manual labour							
Use of both hands							
Use of fine coordination							
Work in cramped conditions							
Work in dusty environment							
Work in environment with fumes							

Section 5: Details of Medical Condition (continue)

Provide any other general comments which may clarify the responses in the table. If improvement is expected, indicate the time frame (period):

Comment on the member's ability to perform activities, and daily living and self care tasks. Advise what is possible and what is not possible:

Comment on the member's current daily activity profile, i.e., how does the member spend their time at present?

Section 6: Functional Abilities

I have enclosed copies of all clinical investigation reports: Yes ☐ No ☐

I have enclosed copies of correspondence form other practitioners, specialists or hospitals: Yes ☐ No ☐

Section 7: Declaration

I hereby declare that I have personally examined and attended to the member and that the contents of this report are true and correct.

Doctor signature

Doctor stamp

D D M M Y Y Y Y

Processing of Personal Information in terms of the Protection of Personal Information Act 4 of 2013

The privacy of our Insured is of utmost importance to us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

The Insured's Personal Information will be used to assess the claim for the Insured. You hereby agree to give honest, accurate and up-to-date Personal Information of our Insured to assist us in assessing the risk insured against.

You acknowledge that any Personal Information supplied to us in respect of the Insured is provided according to the Applicable Laws. Unless consented to by yourself, we will not sell, exchange, transfer, rent or otherwise make available any Personal Information you have provided in respect of our Insured unless it is a requirement in terms of the Applicable Laws.