DISABILITY CLAIM FORM – MEDICAL ATTENDANT'S REPORT

Please return to: Hollard Group Risk, 22 Oxford Road, Parktown, or PO Box 87419, Houghton 2041.
Tel: (011) 351 5000, Fax: (011) 351 3079, email: hgrdisability@hollard.co.za

SECTION A: HOW TO CLAIM

The claimant must obtain at his/her own expense, the medical attendant's report from a registered medical practitioner, who is not a member of the claimant's immediate family. The medical attendant must complete this form to ascertain the diagnosis, changes in functional capacity due to illness or injury, optimal medical treatment and to assess the claimant's degree of medical impairment.

It is essential that this form is fully completed to prevent any unnecessary delays due to missing or incomplete information. This form may be submitted to Hollard by the employer, claimant or the medical attendant.

This form is structured in six sections:

- Section A: How to claim (informative section)
- Section B: Policy details (to be completed by employer or claimant)
- Section C: Claimant's personal details (to be completed by employer or claimant)
- Section D: Medical attendant's details (to be completed by the medical attendant)
- Section E: Medical information (to be completed by the medical attendant)
- Section F: Declaration (to be signed by the medical attendant)

This fully completed form should be accompanied by the following supporting documentation:

- copies of any reports (e.g. EEG, X-rays, previous consultations, etc.)
- copies of any laboratory results (e.g. histology, blood results (including CD4 counts), etc.)
- copies of any additional information to substantiate the claim

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard.

PRIVACY

We respect the confidentiality of your personal and medical information. If necessary, we may need to share either your personal or medical information, or both, with third parties. These third parties are other insurance and or reinsurance companies, or service providers that may assist us in assessing and managing the risk, or servicing you. We impose the same strict confidentiality standards on these third parties as is applied by us.

By providing the required personal and medical information, and signing this declaration of health, you hereby confirm that you consent to us processing and sharing your personal and medical information with other third parties.

SECTION B: POLICY DETAILS (to be completed by the employer or claimant before this form is completed by the medical attendant)

Employer:

Policyholder:

Policy number:

Membership / Employee number:

SECTION C: CLAIMANT'S PERSONAL DETAILS (to be completed by employer or claimant)

First names:

Surname:

Identity number:

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

Gender: M F

SECTION D: MEDICAL ATTENDANT'S DETAILS (to be completed by medical attendant)

Title: First names:

Surname:

Qualification:

Practice number:

Physical address:

Code:

Postal address:

Code:

Telephone number:

Fax number:

Email address:

SECTION E: MEDICAL INFORMATION (to be completed by medical attendant)

1. What is the diagnosis of the claimant's condition?

2. Date of diagnosis of the claimant's condition: D D M M Y Y Y Y

3. When did the first symptoms of the condition claimed for appear? D D M M Y Y Y Y

4. Date of the first consultation? D D M M Y Y Y Y

5. Date of the last consultation? D D M M Y Y Y Y

6. What is the claimant's: height (cm) weight (kg) BP

7. What is the cause of the claimant's condition?

8. What are the resultant limitations experienced by the claimant?

9. How has this condition affected the patient's ability to perform their activities of daily living?

Activity	Description	can	with help	cannot
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.	☐	☐	☐
Mobility	The ability to move indoors from room to room on level surfaces.	☐	☐	☐
Transferring	The ability to move from a bed to an upright chair or wheelchair and *vice versa.*	☐	☐	☐
Dressing	The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	☐	☐	☐
Eating	The ability to feed oneself once food has been prepared and made available.	☐	☐	☐
Toileting	The ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate. The maintenance of continence is included in this activity of daily living although it may be regarded as an activity of daily living on its own.	☐	☐	☐

10. Please provide details of any complications or concurrent conditions:

11. Are you still attending to the claimant? Y N

12. Does the claimant have insight into his/her condition? Y N

If "No", please provide details

13. Please provide details of all consultations in the last five years:

Date	Reason for consultation	Diagnosis	Treatment & Outcome

14. Has the claimant ever been hospitalised for this or any other conditions? Y N

If "Yes", please provide details of hospitalisation:

Date admitted	Date discharged	Reason	Name of hospital

Please provide details of the treatment received during the hospitalisations mentioned above:

Name of hospital	Treatment	Outcome

15. Has the claimant had any special investigations? E.g. X-ray, EEG, tests. Y N

If "Yes", please provide details:

Date	Special investigation	Outcome

16. Has the claimant been referred to any other health care professionals e.g. Physiotherapist, Occupational Therapist, Psychologist or other medical specialists? Y N

If "Yes", please provide details:

Name	Type of Practice/Specialty	From	To	Treatment & Outcome

17. Has any of the following contributed in any way to your condition?

Nature of contributor		Details
Accident (If "Yes", please complete number 4 below):	Y N	
HIV:	Y N	
Previous illness or injury:	Y N	
Hazardous pursuit or pastime:	Y N	
Habits e.g. excessive alcohol consumption:	Y N	
Self-inflicted injuries:	Y N	

18. How has your condition been treated?

Date	Therapy / Medication	Description / Dosage

Please provide more details on treatment by completing the table below:

Aspect		
Strict compliance by claimant with medication / therapy?	Y N	
Is condition satisfactorily controlled?	Y N	
Is claimant undergoing optimal therapy?	Y N	
Is future surgery planned / required / anticipated?	Y N	
If "Yes" please advise when?		

Any additional comments:

19. Please provide an indication of the short-term prognosis with reasons:

20. Please provide an indication of the long-term prognosis with reasons:

21. Please complete the assessment scale below to describe the nature of the claimant's impairment in relation to the following activities of daily work. Please complete section 21.1 and either section 21.2 or section 21.3.
Please tick only the most appropriate response.

21.1 This section must be completed in all instances

21.1.1. Sensory Motor Abilities

(a) Vision and hearing

☐ The claimant's vision and/or hearing abilities, with the use of assistive devices, are not reduced to the extent that physical assistance from another person is required.

OR

☐ The claimant's vision and/or hearing abilities are reduced to the extent that functional abilities are affected and independent functioning without physical assistance from another person in a workplace is impossible, even with the use of assistive devices.

OR

☐ The claimant is entirely functionally blind or deaf.

(b) Speech

☐ The claimant's speech abilities, with the use of assistive devices, are not reduced to the extent that physical assistance is required.

OR

☐ The claimant's speech abilities are reduced to the extent that verbal communication within a workplace requires physical assistance, both through another person and an assistive device.

OR

☐ The claimant is entirely unable to verbally communicate within a workplace, despite physical assistance through another person and an assistive device.

21.1.2. Mobility

☐ The claimant is able to move independently between essential workstations with, at the most, the assistance of a walking cane or other assistive device (including a wheelchair).

OR

☐ The claimant requires partial physical assistance, from another person, even with the use of support apparatus and a walking cane or other assistive device (including a wheelchair), in order to move between essential work stations.

OR

☐ The claimant requires constant physical assistance, from another person, for mobility between essential workstations, despite the workplace meeting the legislative requirements for accessibility.

21.1.3. Cognitive impairment

☐ The claimant's cognitive ability is unimpaired regardless of any presence of irreversible cognitive deterioration or damage that is organic in nature.

OR

☐ The claimant medically requires periodic assistance or direct supervision to perform work tasks, due to deterioration in or damage to cognitive ability, as measured by clinical evidence and standardised tests that is irreversible and organic in origin.

OR

☐ The claimant medically requires constant assistance to perform work tasks, due to deterioration in or damage to cognitive ability, as measured by clinical evidence and standardised tests, that is irreversible and organic in origin.

OR

☐ The claimant is totally unable to perform work tasks despite constant assistance, due to cognitive deterioration or damage, as measured by clinical evidence and standardised tests, that is irreversible and organic in origin.

21.2 Professional / White collar activities of daily work (if applicable).

21.2.1. Work stamina

☐ The claimant is able to meet the full (i.e. 75% to 100%) effort tolerance and endurance requirements, with regular breaks.

OR

☐ The claimant is able to meet 40% to 75% requirements for effort tolerance and endurance, with prolonged rest periods, the use of good ergonomic principles and assistive devices or support system.

OR

☐ The claimant is able to meet at most 40% requirements for effort tolerance and endurance, despite prolonged rest periods, the use of good ergonomic principles and assistive devices or support system.

21.2.2. Co-ordination and dexterity

☐ The claimant is able to use both upper limbs in a coordinated and dexterous manner in order to perform gross and fine motor work activities.

OR

☐ The claimant is able to perform gross motor work activities, albeit in an awkward fashion, but requires physical assistance from another person to perform fine motor work activities, despite appropriate adaptations and assistive devices.

OR

☐ The claimant is unable to perform gross and fine motor work activities despite appropriate adaptations, the use of assistive devices and physical assistance from another person.

21.3 Manual / Blue collar activities of daily work (if applicable)

20.3.1. Physical capabilities
(a) Balance. These are defined as the ability to move between sitting, standing, lifting, kneeling, crouching and bending inherent within work tasks.

☐ The claimant is able to move through the full range of dynamic work postures, with at the most the assistance of a walking cane or other ambulatory device.

OR

☐ The claimant is able to move through a partial range of dynamic work postures but requires physical assistance from another person, in conjunction with a suitable assistive and/or ambulatory device, and requires a prolonged time period.

OR

☐ The claimant is totally reliant on physical assistance from another person, despite use of suitable assistive and/or ambulatory devices, to move between all the dynamic work postures.

22. In your opinion, as at what date was the claimant last able to work? D D M M Y Y Y Y

23. In your opinion when will the claimant be able to engage in any part of his/her occupation in a:

(a) Part-time capacity? D D M M Y Y Y Y

(b) Full-time capacity? D D M M Y Y Y Y

24. If the claimant has already recovered and returned to work, please provide the date of his/her return to work:

D D M M Y Y Y Y

Thank you for your assistance. We wish to advise that we may be requested to provide a copy of the medical attendant's report to other medical practitioners, other insurers and/or legal representatives.

SECTION F: DECLARATION (to be signed and dated by medical attendant)

I hereby declare that I have personally examined and attended to the claimant and that the contents of this report are true and correct. I accept that a copy of this report can be made available to other parties as stated above.

Signed at _____ on this _____ day of _____ 20 _____

Name of Medical Attendant

Signature