# Declaration by attending doctor for an Income Protector / Overhead expenses Protector claim

*Important:*

- *To be completed by the attending doctor only. (If abroad, provide all medical documentation in English)*
- *Any cost involved to complete this form is the responsibility of the claimant.*
- *An accurately completed form is essential in order to avoid delays in the assessment process. Please complete all questions.*
- *Legible copies of original documents may be submitted instead of the originals.*

**Please supply the following additional completed document:**

- Legible copies of certificates of illness provided by attending doctor. *(If available.)*

**Contact details for GUb`Ua ˙=bX]Y˙7`U]a s**

email:claims@sanlamindie.co.za

Plan number(s) ______________________________

## Particulars of claimant

Surname ______________________________

Full first names ______________________________

Date of birth ___/___/______ *(dd/mm/ccyy)*

## Nature of claim and particulars of consultations

The claimant first consulted me for this current condition on ___/___/______ *(dd/mm/ccyy)*

Follow-up consultation dates ___/___/______ *(dd/mm/ccyy)*

___/___/______

___/___/______

___/___/______

Primary diagnosis ______________________________

Diagnostic code (ICD -10) for primary diagnosis ______________________________

Secondary diagnosis ______________________________

Diagnostic code for secondary diagnosis (ICD -10) ______________________________

As a result of the above diagnosis the claimant was **totally** unable to fulfil his/her professional duties for the period (Please also include weekends if they form part of the sick leave period granted) :

From ___/___/______ *(dd/mm/ccyy)* To: ___/___/______ *(dd/mm/ccyy)*

Was the sick leave due to: Illness ☐ Injury ☐ *(Please mark the applicable option with an X.)*

Describe the nature/details of the illness or injury

______________________________

______________________________

Date when the illness first started/injury occurred ___/___/______ *(dd/mm/ccyy)*

Was the claimant hospitalised? Yes ☐ No ☐

If "Yes": Admission date: ___/___/______ *(dd/mm/ccyy)* Discharge date: ___/___/______ *(dd/mm/ccyy)*

Time of admission: ______________ Time of discharge: ______________

Was any surgery performed? Yes ☐ No ☐

If "Yes", please specify the type of operation/procedure.

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______________________________



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Plan number(s) ______________________

## Nature of claim and particulars of consultations *(continuation)*

Date of operation ___/___/______ *(dd/mm/ccyy)*

Operation code (CPT4) ______________________

Were there any complications, which prolonged the sick leave beyond what can be reasonably expected for a condition of this nature? *(Please include copies of specialist reports.)* Yes ☐ No ☐

If "Yes", please comment on these complications as well as the reason for the extended sick leave.

______________________

______________________

______________________

______________________

______________________

Is the insured currently at work? Yes ☐ No ☐

## Particulars of doctor

Full names and surname ______________________

Medical Board Registration Number ______________________

Qualification ______________________

Practice number ______________________

Telephone number (    ) ______________ Fax number (    ) ______________

Postal address ______________________

______________________

e-mail address ______________________

Signature of doctor ______________________

Date ___/___/______ *(dd/mm/ccyy)* Place ______________________


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