Sanlam

# Medical Questionnaire for claims from the regular family doctor

Plan number(s) _____

## Section A: Particulars of claimant

***Must be completed by the Claims Consultant for all claims.***

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Rev ☐ Dr ☐ Prof ☐ Adv ☐ Judge ☐

Surname _____

First name and further initials _____

Identity number / Passport number _____ Country of Issue _____

Date of birth _____ *(dd/mm/ccyy)*

Postal Address _____

Residential Address _____

_____

## Section B: Particulars of family doctor/practitioner

***Must be completed by the family doctor/practitioner.***

First name, further initials and surname _____

Telephone number (____) _____ Fax number (____) _____

Qualifications _____

Signature _____ Date *(dd/mm/ccyy)*

**Compensation payable**

Full name of practice or partnership _____

Address _____

Practice code _____ VAT Registration number _____

| Tariff code | Description | Fee payable | |
|---|---|---|---|
| 1401 | General practitioner | R 400.60 | (Fee payable according to ASISA tariff.) |
| 4102 | Specialist physician | R 479.70 | |

## Personal medical adviser's report

We have received a claim from the person as indicated above. To be able to consider the insurance claim, a report from a personal medical adviser is required. We will appreciate it if you can answer the questions in this form.

**Important:** The claimant has authorised us to obtain this information from you (and has requested you to provide us with this information) and to share it with other life offices direct, or through ASISA for purposes of underwriting and/or claims assessment. In terms of ASISA protocol the claimant may enquire about information held by ASISA. Such information will be made available to him/her by his/her nominated medical practitioner.

Plan number(s) _____

## Section C: Details of consultations BEFORE _____ *(dd/mm/ccyy)*

1. Provide details of illnesses for which the claimant consulted you BEFORE _____ *(dd/mm/ccyy)*

| **Illness** | **Medication and treatment** | **Date of first consultation** *(dd/mm/ccyy)* | **Date of last consultation** *(dd/mm/ccyy)* |
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1.1 Please provide copies of all clinical records in your possession:

1.1.1 Do you have any records? Yes ☐ No ☐

1.1.2 Is it attached? Yes ☐ No ☐

2. Consultations with other doctors of which you are aware of?

| **Name and address of doctor** | **Illness** | **Date of consultation** *(dd/mm/ccyy)* |
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2.1 If you have any copies of reports with reference to these consultations, please provide.

2.1.1 Do you have any records? Yes ☐ No ☐

2.1.2 Is it attached? Yes ☐ No ☐

Plan number(s) _____

3. Hospitalisation

3.1 Was the claimant ever hospitalised for any condition? Yes ☐ No ☐

3.2 If "Yes", please provide the following information:

| **Name of Hospital** | **Illness** | **Date of hospitalisation** *(dd/mm/ccyy)* |
|---|---|---|
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3.3 If you have any copies of reports with reference to the hospitalisation, please provide.

3.3.1 Do you have any records? Yes ☐ No ☐

3.3.2 Is it attached? Yes ☐ No ☐

4. Special investigations for any condition

4.1 Were laboratory or special investigations done? Yes ☐ No ☐ *(e.g. liver/lung functions, MT, MRI's, CT scan, X-rays, etc.)*

4.2 If "Yes", please provide the following information:

| **Type of test/investigation** | **Date** *(dd/mm/ccyy)* | **Result** |
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4.3 If you have any copies of reports with reference to these tests or investigations, please provide.

4.3.1 Do you have any records? Yes ☐ No ☐

4.3.2 Is it attached? Yes ☐ No ☐

5. Chronic Medication

5.1 Is the claimant using chronic medication? Yes ☐ No ☐

5.2 If "Yes", please provide the following information:

| **Name of Medication and dosage** | **Reason for medication** | **Start Date** *(dd/mm/ccyy)* | **End Date** *(dd/mm/ccyy)* | **Still on treatment?** Yes / No |
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