Medical certificate by regular family doctor
Death claims

Please complete the medical certificate and return to:

Sanlam Indie Claims

E-mail address: claims@sanlamindie.co.za

Medical information before ____/____/____ *(dd/mm/ccyy)*

Policy number _____

On the life of the late (full names and surname) _____

Identity number _____

Particulars of doctor

Complete this document only if you are to provide us with the full clinical records of the deceased. Only then will Sanlam Life accept responsibility for the payment of the account.

Full names and surname _____

Practice address _____

_____ Postal code _____

Practice number _____ VAT number _____

The fee payable is that for item A1405 of the "Tariff of fees for life assurance". Please attach the VAT invoice, if any, and your account to the report.

Telephone number: Work (____) _____ Home (____) _____

Cell _____ Fax (____) _____

1. General

1.1 Were you the deceased's family doctor? Yes ☐ No ☐

If so, since which date: ____/____/____ *(dd/mm/ccyy)*

Date of first consultation ____/____/____ last consultation ____/____/____

1.2 If not, please state the name, address and telephone number of the regular family doctor:

Name of doctor	Address	Telephone number

1.3 Name of deceased's medical aid: _____

Deceased's medical aid member number _____

Policy number _____

On the life of the late (full names and surname) _____

2. Death particulars

2.1 Date of death ____/____/____ *(dd/mm/ccyy)*

2.2 Cause of death _____

_____

2.3 Contributory or related cause:

Illness	Medication and treatment	Date of first consultation	Date of subsequent consultation

2.4 Was a post-mortem done? Yes ☐ No ☐

2.5 What were the findings of the post-mortem? _____

3. HIV

3.1 Was the deceased tested for HIV anti-bodies, CD4, viral load at any stage? Yes ☐ No ☐

If "Yes", please state the following:

The date of the test(s): ____/____/____ *(dd/mm/ccyy)*

The result of the test(s): _____

The name, address and telephone number of the institution which carried out the test(s):

_____

_____

3.2 Do you have reason to suspect on clinical grounds, that he/she may have been HIV positive at the time of death? Yes ☐ No ☐

If "Yes", please motivate.

_____

_____

4. Other illnesses about which the deceased consulted you

Please supply all the clinical records before ____/____/____ *(dd/mm/ccyy)*

Illness	Medication and treatment	Date of first consultation	Date of subsequent consultation

Policy number _____

On the life of the late (full names and surname) _____

5. Consultation with other doctors of which you are aware

Please supply the relevant reports before ____/____/_____ *(dd/mm/ccyy)*

Name and address of doctor	Illness	Date of consultation *(if known to you)*

6. Hospitalisation

Please supply the relevant information before ____/____/_____ *(dd/mm/ccyy)*

6.1 Was the deceased ever hospitalised? Yes ☐ No ☐

If "Yes", please provide the following information:

Name of hospital	Address and telephone number of hospital and doctor	Illness	Date of hospitalisation	Patient's hospital number

6.2 Laboratory or special investigations, i.e. liver, lung function, HbA1C tests, etc.

Type of tests/investigations	Date	Results of tests

Policy number _____

On the life of the late (full names and surname) _____

7. Habits

Please supply the relevant information before ____/____/_____ *(dd/mm/ccyy)*

Alcohol/Drugs

7.1 Did the deceased abuse alcohol/drugs? Yes ☐ No ☐

The date of the first consultation ____/____/_____ Subsequent consultation ____/____/_____

- Was the assured ever admitted to a hospital/institution for the treatment of alcohol or drug abuse? Yes ☐ No ☐

  If so, please state:

Name, address and telephone number of the hospital/institution and doctor	Date of admission	Patient's hospital number

- Was Antibuse prescribed? Yes ☐ Nee ☐

  If so, state the type and date(s) _____

  If any liver or lung function test(s) was done, provide a copy of the relevant reports.

Smoking

7.2 Did the deceased smoke? Yes ☐ No ☐

If so, since when: ____/____/_____ *(dd/mm/ccyy)*

8. Hypertension

Please supply the relevant information before ____/____/_____ *(dd/mm/ccyy)*

Blood-pressure reading	Date	Blood-pressure reading	Date

8.1 What medication was prescribed?

_____

_____

8.2 Were there any target-organ damage?: (eye, kidney, heart, blood vessels) Yes ☐ No ☐ *If "Yes", specify*

_____

8.3 Were any ECG's taken? Yes ☐ No ☐

If so, state the dates and results (access to the ECG's would be appreciated).

_____

_____

Policy number _____

On the life of the late (full names and surname) _____

9. Diabetes

Please supply the relevant information before ____/____/_____ *(dd/mm/ccyy)*

9.1 Please state the measure of control (HbA1C).

_____

9.2 Were there any target-organ damage?: (eye, kidney, heart, blood vessels) Yes ☐ No ☐

9.3 If so, state the organ _____

10. Ischemic heart disease

Please supply the relevant information before ____/____/_____ *(dd/mm/ccyy)*

10.1 Was an angiograph done? Yes ☐ No ☐

10.2 Was the result normal or abnormal? _____

Access to any ECG's lipograms and specialists' reports would be appreciated.

11. Psychological/mental disorders

Please supply the relevant information before ____/____/_____ *(dd/mm/ccyy)*

11.1 Please state the nature of your treatment and/or psychotherapy.

_____

_____

11.2 How did the patient respond to your treatment?

_____

11.3 Were there any attempts to commit suicide? Yes ☐ No ☐

If so, please state the date(s) _____

11.4 State the name, address and telephone number of any hospital/clinic/institution to which the patient was admitted or any psychologist/psychiatrist who was consulted, with specific dates as well as the hospital number where applicable.

Name	Address	Telephone number	Date admitted	Patient's hospital number

12. Chronic obstructive airway

Please supply the relevant information before ____/____/_____ *(dd/mm/ccyy)*

Were there any periods when the following took place? If so, state the date of each treatment:

12.1 Cortisone therapy: Yes ☐ No ☐ ____/____/_____ *(dd/mm/ccyy)*

12.2 Hospitalisation: Yes ☐ No ☐ ____/____/_____ *(dd/mm/ccyy)*

12.3 Maintenance therapy: Yes ☐ No ☐ ____/____/_____ *(dd/mm/ccyy)*

Declaration of doctor

I, the undersigned, certify that the above-mentioned information is correct.

Signature _____

Date ____/____/_____ *(dd/mm/ccyy)* Place _____