FAMILY RESPONSIBILITY RIDER BENEFIT – TERMINAL ILLNESS BENEFIT FORM (CHILD) (DECLARATION BY DOCTOR) NAMIBIA

The Professional Provident Society Insurance Company (Namibia) Limited Reg. No 2003/122 is a registered long-term insurance provider regulated by the Namibia Financial Institutions Supervisory Authority. Any reference to PPS Namibia in this form means PPS Insurance Company (Namibia) Limited.

Dear Doctor,

We appreciate your time and cooperation in assisting PPS Namibia to assess your patient's claim accurately.
Kindly provide comprehensive answers to the questions listed below and attach copies of all relevant investigations available to you.

PPS Namibia obtained prior written consent from the life-insured in terms of which medical information pertaining to the claim may be provided. PPS Namibia may also be obliged to release such medical information, obtained as part of the claims assessment process, to the policyholder at their request. Furthermore, PPS Namibia may be legally obliged to share the medical information with a third party.

By providing the medical information, you hereby consent to the sharing and further processing thereof. PPS Namibia undertakes that it will share and process such medical information in accordance with the purpose for which it was collected, which may include instances of complaints or dispute resolution. However, the utmost care will be taken to prevent any unreasonable or unlawful disclosure.

Please send the fully completed form and supporting documentation to PPS Namibia claims at namibiaclaims@pps.co.za

PART A: MEMBER DETAILS

Member number:

Initials: Surname:

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

E-mail:

Cell phone:

PART B: DETAILS OF THE CLAIM

Particulars of the patient

Name:

Surname:

ID/Passport number (if no ID):

PART C: MEDICAL ILLNESS

1. Primary diagnosis: ICD 10 code:
2. Secondary diagnosis (if applicable): ICD 10 code:
3. Provide **date of initial consultation** and brief details of the **chronological history** of the illness or sequence of events:

4. Treatment or investigations conducted for the terminal illness:

NOTE Please attach copies of all relevant investigations conducted.

Date	Details	Doctor

5. Is there further treatment available for this illness? Please give details:

6. What is your patient's life expectancy (in months), based on your medical findings?

PART D: MEDICAL PRACTITIONER'S DETAILS

HPCNA reg no.: Practice no.:

Initials: Surname:

Telephone:

E-mail:

Address:

Postal code:

Signed at this day of 20

Signature of medical attendant

DISCLAIMER:

By submitting this form electronically, you acknowledge that your electronic signature holds the same legal weight as a handwritten signature. For authorised electronic signature details, contact your financial adviser or e-mail namibiaclaims@pps.co.za. Using unauthorised electronic signatures is at your own risk and PPS Namibia disclaims liability for any related issues.