

CLAIM FOR SICKNESS BENEFIT - DECLARATION BY MEMBER NAMIBIA FOR CLAIM RELATED TO COVID-19 (CORONAVIRUS) INFECTION

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.



IMPORTANT

1. All medical information will be treated with confidentiality.
Any costs incurred in obtaining the supporting document(s) will be for the life-insured's account.

2. PPS Namibia contact details:

Claim submissions:

E: namibiaclaims@pps.co.za

F: +264 (0)61 411 330

Claim-related enquiries:

E: namibiaclaims@pps.co.za

T: +264 (0)61 411 300

Monday to Friday 08:00 to 16:30

F: +264 (0)61 411 330

COVID-19-related sick leave claim requirements		
Topic		Requirements and notes
A	All types of COVID-19 claims	<ul style="list-style-type: none"> • Copy of COVID-19 test result • Declaration by Member Claim form • Declaration by Doctor Claim form <p>PPS Namibia aims to pay all valid claims timeously. Accurately completed forms facilitate the assessment process and allows for a correct assessment.</p>
B	Claim duration	
1	Ten days or less	<p>As noted in A above.</p> <p>Most people who contract COVID-19 are asymptomatic or have mild symptoms that will not prevent them from working remotely. This is especially evident once vaccinated. Some people, however, will suffer moderate to severe symptoms that prevent them from performing some or all of their usual professional duties. People who contract COVID-19 generally recover sufficiently to resume work duties within ten days.</p>
2	Exceeding ten days	<ul style="list-style-type: none"> • In addition to A above, a medical report that includes copies of all relevant medical, blood and special investigations undertaken. • Any other relevant documentation to justify the need for extended recovery. <p>Refer to the addendum attached to the Declaration by Doctor form for a set of specific requirements to substantiate extended claims.</p>
C	COVID-19 complications	<ul style="list-style-type: none"> • A detailed breakdown of the complications and a medical report that include copies of all relevant medical, blood and special investigations undertaken. • Any other relevant documentation to confirm the complications and substantiate the need for extended recovery. • Refer to the addendum attached to the Declaration by Doctor form for a set of specific requirements to substantiate extended claims.
D	Long COVID-19	<ul style="list-style-type: none"> • Beyond the initial period of infection, claims should be submitted to PPS Namibia monthly. • Claim forms should be signed and submitted after the period claimed for, as claims cannot be assessed prospectively.

PART A: MEMBER DETAILS

Member number:

Surname: Initials:

Medical aid name: Medical aid number:

E-mail: Cellular:

PART B: PARTICULARS OF CLAIM

1.1 Provide **details of the disease/condition** that **significantly prevented** you from performing your **usual professional duties** and **required optimal medical treatment or supervision** such as: medication, hospitalisation, surgery or rehabilitation.

1.2 Date of onset of disease/condition:

1.3 Describe the **symptom(s) of the disease/condition** and **how it affected** your **ability to perform** your usual **professional duties**:

1.4 Date symptom(s) of the disease/condition ended:

1.5 Testing for COVID-19
Have you been tested for COVID-19? YES NO

Date of sample collection	Type of test e.g., PCR, antibody test, rapid antigen test	Result	Result date

1.6 Describe the **complications experienced** and **how it influenced** your **ability to perform your professional duties (where applicable)**:

2. Did the illness originate outside a Southern African Development Community (SADC) country? YES NO

If YES, specify country:

3. Details of hospitalisation and rehabilitation

3.1 Hospitalisation

Did you require admission to hospital? YES NO

Name of hospital:

Attach a copy of the admission sheet or the hospital account showing admission and discharge dates if you were hospitalised for at least four consecutive days and wish to claim against your Admission Rider benefit (if applicable).

3.2 Rehabilitation

Studies have shown that **early intervention** with rehabilitation, e.g., physiotherapy, occupational therapy, counselling or biokinetics has **yielded positive results**.

Describe the measure/management you and your specialist have undertaken/are undertaking to improve your symptoms:

Date rehabilitation commenced:

Date rehabilitation stopped:

If rehabilitation was stopped, kindly provide reasons:

4. Please state the name(s) of the doctor(s) and allied medical practitioner(s) who attended to you, in respect of this claim. It may be necessary for our claims area to contact them for further information.

Practitioner's initials and surname	Consultation date(s)	Tel	E-mail

5. Claim dates

TOTAL BENEFITS

I was **NOT** able to perform **ANY** professional duties:

From: To:

PARTIAL BENEFITS

I was able to perform some of my work duties while recuperating at home or worked for a limited period per day.

From: To:

DATE OF RETURN TO WORK:

On a partial basis: On a full-time basis:

Provide **details of the duties** that you were **able to perform remotely**, focusing on the nature of the duties performed and time spent performing them e.g., administrative work, virtual consultations, etc.:

PART C: EMPLOYMENT QUESTIONS RELATED TO THE WORK PERFORMED DIRECTLY BEFORE THE CLAIM

6. Please state the following regarding your occupation:

a) Current occupation:

b) Commencement date of occupation:

c) **Tick the option(s) applicable to you:**

i. Are you a healthcare worker? YES NO

ii. Are you self-employed? YES NO

iii. Are you able to work remotely? YES NO

d) Describe the nature of your usual professional duties:

7. ONLY COMPLETE if self-employed:

State the name of your practice/business:

Gross professional income

(Annual income from professional fees and nett income from trading activities):

(Minus) Actual expenses

(Expenses incurred in the running of the business that are not remunerated to the professional. Expenses that will terminate if the business is sold or closed):

(Equals) Personal income (Gross professional income minus actual expenses):

8. ONLY COMPLETE if in salaried employment

State the name of your employer:

State your annual income as:

Annual total cost to company

(Annual salary plus all fringe benefits):

(Plus) Performance bonus (Average over the last three years):

(Equals) Total gross (Professional income):

9. What is the source of the funds being used to pay the premiums for this product?

Please tick the most appropriate option:

Salary/income generated from occupation:

Trust:

Investments:

Other; please specify

PART D: BANKING DETAILS FOR SICKNESS BENEFIT VIA EFT

NOTE Financial governance requires that all benefits regarding sickness claims must be settled to the same account from which your premiums are paid (**premium-paying account**). Please note that this is an improved security measure to mitigate financial risks for claiming policyholders.

Please provide alternative bank details below if you cannot receive payment to your premium-paying account for any reason.

Changing the account to which claim benefits are paid will require additional diligence and proof.

The required additional diligence will take an additional five working days before payment can be made.

If you must change your banking details, please include the required proof together with this claim form.

I understand this note and request PPS Namibia to: *(Select the appropriate option)*

1. Pay any benefits due to my existing premium-paying account.

2. Use the new account details below to pay any benefits due to me.

2.1. Please update my premium-paying account to the new details below for future premium payments. YES NO

Name of account holder:

Name of bank:

Account number:

Branch code:

Type of account:

If you have selected option 2 above, please provide PPS Namibia with proof of account and certified proof of the account holder's identity. The accepted proof of account is a bank-stamped verification letter on the bank's letterhead not older than three months. PPS Namibia cannot make changes to this account without the required proof.

Foreign bank accounts: *Please note that in terms of the PPS Namibia Provider™ Policy, premiums from the policyholder should be paid from a Namibian bank account and benefits to the policyholder should also be paid into a Namibian bank account, in Namibian currency. Accordingly, PPS Namibia assumes no responsibility or liability whatsoever in the event the policyholder pays premiums from a foreign bank account, or the policyholder nominates a foreign bank account for receipt of policy benefits. Furthermore, any payment to and from PPS Namibia involving a foreign bank shall be at the sole discretion of PPS Namibia and subject to the Namibian foreign exchange regulations and other relevant legislation as amended from time to time. PPS Namibia assumes no responsibility or liability to inform the policyholder of any changes in such regulations and legislation.*

Indemnity: Please note that PPS Namibia will not be held liable for incorrect payments if the account information supplied is incorrect. By signing this form, the policyholder indemnifies PPS Namibia and holds PPS Namibia harmless against any losses, liabilities, claims, charges, expenses, costs or any other actions or demands of whatever nature, which could or might be suffered or incurred by the policyholder or any third party whether directly or indirectly, caused by and/or arising out of the payment into the above account.

PART E: AUTHORISATION TO COMMUNICATE WITH FINANCIAL ADVISER

I specifically authorise PPS Namibia to communicate any requirements to my/member's financial adviser which may entail providing information regarding my current medical condition. YES NO

Financial adviser's name:

Financial adviser's e-mail:

PART F: DECLARATION

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I (member full name and surname) and ID number:

authorise PPS Namibia to:

- a) Access any information deemed necessary to assess any insurance risk or to consider a claim. I understand that if I choose not to provide this information, PPS Namibia will not be able to assess my claim for insurance.
- b) Share with other insurers and their representative body any information in the possession of PPS Namibia, either directly or through a database operated by, or for insurers as a group and authorise PPS Namibia to also collect my personal information from other insurers as exchange of information helps to save costs and combat fraud. PPS Namibia can further process any such information in accordance or compatible with the purpose for which it was collected.
- c) Disclose any information to the PPS Holdings Trust, PPS Namibia's subsidiaries and affiliates or other persons provided that it is necessary to properly underwrite, manage, assess the claim or service the policy, policy assets or myself. PPS Namibia may be required to disclose my information to regulatory or government agencies.
- d) Obtain credit information from any person or institution.

AND

I understand that I can request details of the information held by my insurer and request its correction where appropriate.

AND

I authorise a doctor, hospital, medical aid or any other person to provide this information to PPS Namibia. PPS Namibia will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS Namibia will adhere to any laws governing the protection of (and access to) personal information and will not use your information for any purpose not provided for in your Policy Contract and in this Part F.

Signature of policyholder:

Signed at on this day of 20

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 PPS Namibia-accredited 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.