PROFESSIONAL HEALTH PRESERVER – DOCTOR (PPS INSURANCE 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 Insurance Namibia in this form means PPS Insurance Company (Namibia) Limited.

Dear Doctor,

We appreciate your time and cooperation in assisting PPS Insurance Namibia to assess your patient's claim accurately.

Kindly provide comprehensive answers to the questions listed below, **a comprehensive medical report and attach copies of all relevant investigations** available to you.

PPS Insurance Namibia obtained prior written consent from the life-insured in terms of which medical information pertaining to the claim may be provided. PPS Insurance 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 Insurance Namibia may be legally obliged to share the medical information with a third party. Third parties include legal representatives, regulatory bodies or independent dispute resolution authorities acting under lawful authority.

You hereby consent to the sharing and further processing of the medical information for the specific purpose of claim assessment, dispute resolution and policyholder communication. PPS Insurance 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 Insurance Namibia Claims at namibiaclaims@pps.co.za

PARTICULARS OF LIFE-INSURED

Member number: ______ ID/Passport number (if no ID): ______

Surname: ______ Initials: ______

DETAILS OF CLAIM

Please note that the assessment of this claim may depend on the severity of your patient's condition.

1. Primary diagnosis and ICD-10 code (compulsory field):

Date of diagnosis: D D M M Y Y Y Y Date of onset of symptoms: D D M M Y Y Y Y

Date of first consultation: D D M M Y Y Y Y

1.1 Indicate the staging if applicable, e.g., AJCC, FIGO.

2. Secondary, contributory or concurrent medical conditions:

3. Name of current and previous medical practitioners who have treated your patient for this condition:

Doctor's name	Contact details and e-mail address	Speciality	Date of initial consultation	Date of last consultation

MEDICAL PRACTITIONER DETAILS

HPCNA reg no: ___ Practice no: ___

Initials: ___ Surname: ___

Tel: ___ ___

E-mail: ___

Signed at ___ this ___ day of ___ 20 ___

Signature of medical doctor: ___

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 Insurance Namibia-accredited financial adviser or e-mail namibiaclaims@pps.co.za. You accept responsibility for the legitimacy of the submitted electronic signature. PPS Insurance Namibia will rely on technical audit trails and platform controls to determine responsibility in the event of a signature dispute.