

**PPS PROFESSIONAL LIFE PROVIDER™ (PLP)  
LIFE ASSURANCE (LA)  
TERMINAL ILLNESS BENEFIT (DECLARATION BY 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 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](mailto:namibiaclaims@pps.co.za)**

**PARTICULARS OF LIFE-INSURED**

Surname:  Initials:

ID/Passport number (if no ID):

**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 condition or sequence of events:

4. List the investigations that were performed to confirm the diagnosis and attach copies of all the test results:

Date	Details

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?

