OLDMUTUAL

GREENLIGHT

RSA DISABILITY BENEFIT CLAIM FORM

STATEMENT BY MEDICAL ATTENDANT

Contract number

Intermediary Code (e.g. PFA: A123456 BROKER: 78870)

Please print in block letters using black or blue ink.
This form is issued without admission of liability and must be signed by the life covered and the medical attendant.

Please email the completed form to claims@oldmutual.com

Intermediary/Admin support:

Name of contact person

Email address and telephone number of contact person

IMPORTANT NOTES

There may be further requirements before the claim can be considered.

Please enclose copies of any special investigations, e.g. medical reports, ECGs, X-rays, blood tests, laboratory test results, etc. done since the medical condition commenced.

SECTION 1 DETAILS OF CLAIMANT

Title: Mr Ms Mrs Other Initials

Surname

Full names

Previous surname (if applicable)

ID/Passport number Date of birth D D M M Y Y Y Y

Income tax number

Residential address Postal code

Postal address Postal code

Country of address

Contact number (Work) Code No.

(Home) Code No.

Cellphone number

Email address

SECTION 2 REQUEST TO MEDICAL SPECIALIST, HOSPITAL OR CLINIC

Date D D M M Y Y Y Y

Practitioner's name

Address Postal code

Please complete the Confidential Medical Report on the overleaf in respect of the medical condition for which you have been treating me.

I authorise you to disclose to Old Mutual any information you may have concerning my health and habits.

The cost of completing this form and supplying any additional medical information is at the customer's own expense.

Signature of life covered

SECTION 3 CONSULTATIONS

3.1 Since when were you the life covered's doctor? D D M M Y Y Y Y

3.2 When were you first consulted in connection with this medical condition? D D M M Y Y Y Y

3.3 State the dates of all subsequent consultations regarding this medical condition (including today).

D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y

3.4 Are you still in attendance? YES ☐ NO ☐

If "YES", please provide the date of last consultation and examination. D D M M Y Y Y Y

SECTION 4 PATHOLOGY

4.1 What is the life covered's medical diagnosis?

4.2 What was the exact cause of the medical condition (e.g. accident, illness)?

4.3 State the date of commencement of illness or injury. D D M M Y Y Y Y

4.4 Which body parts or systems are affected by the medical condition?

4.5 Describe in full the nature, extent and severity of the medical condition to each body part or system.

4.6 Is the present disablement total and permanent? YES ☐ NO ☐

4.7 What is the medical prognosis for recovery?

4.8 What is the functional prognosis for recovery?

4.9 What is the probable duration of the medical condition?

4.10 In your opinion, is the life expectancy of the life covered impaired by the condition? YES ☐ NO ☐

If so, to what extent?

4.11 Do you have any reason to believe that the medical condition is in any way attributable to any of the following:

	YES	NO
(a) A previous illness or injury	☐	☐
(b) AIDS or HIV infection	☐	☐
(c) A congenital disorder	☐	☐
(d) Attempted suicide or self-injury	☐	☐
(e) Depression or dysthaemia	☐	☐
(f) Chronic fatigue syndrome	☐	☐
(g) Fibromyalgia	☐	☐
(h) Post traumatic stress disorder	☐	☐
(i) Consumption of alcohol or drugs (except under prescription from a medical practitioner)	☐	☐

Please describe in full if answered "YES":

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SECTION 5 TREATMENT

5.1 Please give full details of past and present treatment including medication, rehabilitation, physiotherapy, behavioural therapy, etc.

5.2 When did this treatment commence? D D M M Y Y Y Y

5.3 How often does the life covered require such treatment?

5.4 How well has the patient adhered to the treatment regime?

5.5 Has the condition been receptive to treatment? YES NO

5.6 Is there any other treatment recommended, for example rehabilitation, medication, etc.?

5.7 Is the severity of the medical condition likely to change substantially over the next year?

With treatment YES NO

Without treatment YES NO

SECTION 6 IMPACT ON ACTIVITIES

6.1 Please describe the current and expected future impact of the medical condition on the ability to perform the following activities:

	Current	Future
Thinking clearly		
Concentrating		
Making decisions		
Interacting with others		
Walking		
Sitting in a chair		
Writing and typing		
Reading		
Operating machinery		
Carrying and lifting		
Driving		
Feeding		
Toileting		

6.2 Are there any other daily activities that are impaired by the patient's condition? YES NO

Please describe in full.

6.3 Is there a medical reason to believe that the patient is likely to suffer any harm by engaging in usual activities of daily living or other activities necessary to meet personal, social or occupation demands? YES NO

Explain briefly.

6.4 Please describe how, if at all, assistive devices may be used to enable the patient to perform normal daily activities.

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6.5 Is the life covered confined to:

(a) A bed?	
(b) The house?	

If ambulant, to what degree?

6.6 What was the life covered's occupation immediately before his/her current disablement?

(a) When was the life covered last able to perform any part of the duties of his/her occupation? D D M M Y Y Y Y

(b) Do you think that the life covered will in future be able to engage in his/her occupation? YES NO

If "YES", when is the life covered likely to be able to do so?

SECTION 7 MEDICAL HISTORY

7.1 Who referred this patient to you?

Practitioner's name	
Contact number	

7.2 Has the patient consulted any other medical practitioner or has he/she been hospitalised? YES NO

If "YES", please state name(s) and address(es) of medical practitioner(s) and hospital(s) involved, and referral date(s).

Name	Address	Medical condition	Date	Duration

7.3 Is the patient a member of a medical aid? YES NO

Name of medical aid	
Member number	
Name of main member	

SECTION 8 DECLARATION BY MEDICAL ATTENDANT

I certify that I have personally attended to the patient (life covered) and that all the foregoing statements are correct to the best of my knowledge.

Initials

Surname

Full names

Practice number

Qualification

Contact number

Address

Postal code

I certify that I have personally attended to the patient and that all the foregoing statements are correct to the best of my knowledge. I confirm that I will adhere to all the applicable Data Protection legislation.

Signed at (place) on (date) D D M M Y Y Y Y

Signature of medical attendant

Old Mutual Claim Contact Details:

Email	claims@oldmutual.com	Fax number	0860 60 45 02
Telephone number	RSA: 0860 10 22 74 International: +27 21 503 1802	Address	PO Box 202, Mutualpark 7451, South Africa.

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