Living Plan

Medical Report

(in support of Physical Impairment claim)

Form

EMAIL COMPLETED & SIGNED DOCUMENTS TO:
claims@onespark.co.za

To be completed by Attending Medical Practitioner in block letters and black ink.

Dear Doctor,

This medical information requested in this report is in support of a policy benefit payable for the life insured. Your expertise and advice will provide a vital link in the process of assessing the claim. Please ensure you have confirmed the identity of the person in respect of whom this information is provided (using photographic form of identity)

As this report is in support of a claim application, any cost in connection with this report will be for the account of the life insured in terms of the policy, unless otherwise specified by OneSpark and confirmed in writing.

The privacy of our Insured is of utmost importance to us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

The Insured's Personal Information will be used to assess the claim for the Insured. You hereby agree to give honest, accurate and up-to-date Personal Information of our Insured to assist us in assessing the risk insured against.

You acknowledge that any Personal Information supplied to us in respect of the Insured is provided according to the Applicable Laws. Unless consented to by yourself, we will not sell, exchange, transfer, rent or otherwise make available any Personal Information you have provided in respect of our Insured unless it is a requirement in terms of the Applicable Laws.

We thank you for your co-operation.

Section A: Medical Practitioner details

Full names and surname:

Address:

E-mail address:

Cell phone number:

Business telephone number:

Practice number:

HPCSA registration number:

Qualification:

Section B: Insured Person details

Policy number:

Full names:

Surname:

ID number:

Name of hospital/clinic:

Hospital/Clinic file number:

Section C: Medical history

Are you the claimant's regular doctor? ☐ Yes ☐ No

• If not, please provide the name and telephone number of the doctor who referred this patient to you:

Please give the details of any practitioners, specialists or hospitals to which the insured has been referred. Please include copies of all available specialist reports and any investigations performed.

Name of Doctor	Contact details of doctor	Name of facility (e.g. hospital name)	Consulation Date	Treatment details	Date of last visit to doctor

Has the Insured ever been tested for HIV antibodies? ☐ Yes ☐ No Date:

Result: (PLEASE ATTACH RESULTS)

Did the insured use tobacco in any form? ☐ Yes ☐ No

If so, how much

Did the insured consume alcohol on a weekly basis? ☐ Yes ☐ No

If yes, how many units per week?

Did you ever advise the insured to reduce their alcohol consumption? ☐ Yes ☐ No

Section D: Details of Insured Person's Impairment

(Please tick the relevant block, supply reports where indicated and answer questions in the spaces provided):

General

All changes reflected in the below definitions must be permanent and irreversible, despite treatment according to recognized medical protocols. The diagnosis must be supported by the appropriate objective investigations and test results.

DISABILITY CATEGORY	DISABILITY	Tick box
Nervous	Total, permanent and irreversible loss of comprehension of language	☐
	Quadriplegia	☐
	Paraplegia	☐
	Hemiplegia (Total, permanent and irreversible loss of function)	☐
	Total Loss of vision in both eyes (permanent and irreversible loss of all vision with no light perception in both eyes)	☐
Musculoskeletal	Total, permanent and irreversible loss of use of both hands	☐
	Total, permanent and irreversible loss of use of both feet	☐
Cancer	Any stage IV cancer	☐

Additional Information regarding the Claim's assessment:

Nervous

All changes must be total, permanent and irreversible. Functional psychiatric disorders are excluded.

- Paraplegia, Hemiplegia and Quadriplegia
  - Diagnosis and clinical findings including range of movement, power and sensation (after full rehabilitation has been completed)

- Loss of vision
  - Vision acuity pre- and post-correction
  - Visual field where applicable

Musculoskeletal

All changes must be total, permanent and irreversible. The diagnosis must be supported by the relevant investigations and reports.

- Amputation
  - Sketches indicating the level of amputation

- Loss of Use of Body Part
    - Clinical findings indicating range of movement of the joints, power, sensation, ankylosis (with position), neurological Impairment, including radiographic and electroconduction study results, where appropriate.

Cancer

A medical report is required, including the histology.

What is the immediate cause of physical impairment or illness?

Date of accident or commencement of illness (if know):

Date of accident or commencement of illness (if know):

Date the insured first became aware of the symptoms (if illness):

Was the Insured suffering from this condition when you were first consulted? ☐ Yes ☐ No

Please provide full details of past and present treatment including medication, rehabilitation, etc.

How has the patient's condition responded to treatment?

Is the patient's current impairment permanent and irreversible? What is the prognosis for recovery?

State fully if any of the following contributed or predisposed to the cause of physical impairment:

Previous Illness/injury:

Habits:

Was the accident or illness due to any of the following:

1. Intentional self-inflicted injury?

   ☐ Yes ☐ No

   If 'Yes', please specify

2. Intentional and negligent consumption of poisons, drugs and narcotics unless prescribed by a registered Medical Practitioner?

   ☐ Yes ☐ No

   If 'Yes', please specify

Declaration by Medical Practitioner

I hereby declare that I have personally examined and attended to the life insured and that the contents of this report are true and correct.

Full names and surname

Doctor’s signature

Date