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TRIARC is an authorised financial services provider FSP45009

# GROUP RISK DREAD DISEASE BENEFIT CLAIM FORM – MEDICAL REPORT

**Please complete form in block letters**

**Dear Health Professional**

Please answer each question in full. Do not use a dash, correction fluid or leave blank. Include copies of test results and reports for example pre- and post-operation reports, histology reports, blood test results, x-ray reports, ECG and scans to support the diagnosis. The claimant is responsible for the cost of the initial medical report.

## Section 1. Health Professional Details

| Field | |
|---|---|
| Surname | |
| First Name(s) | |
| Qualifications/Speciality | |
| Other Qualifications | |
| Practice Number | |
| HPSCA Registration No. | |
| Practice Address | |
| | Code |
| Telephone Number (W) | |
| Telephone Number (F) | |
| Cellphone Number | |
| Email Address | |

## Section 2. Scheme Details

| Field | |
|---|---|
| Scheme Details | |
| Policy Number | |

## Section 3. Details of Claimant

| Field | |
|---|---|
| Surname | |
| First Name(s) | |
| Maiden Name or previous name | |
| ID Number | |
| Date of Birth | Y Y Y Y M M D D |
| Country of Origin | |
| Hospital or File Number | |
| Name of Employer | |
| Telephone Number | |
| Cell Number | |

## Section 4. Consultation History

| | |
|---|---|
| Date of your first ever consultation with the member | Y Y Y Y M M D D |
| Date of your first consultation with regards to the current symptomology | Y Y Y Y M M D D |
| Date of your last consultation with regards to the current symptomology | Y Y Y Y M M D D |

## Section 5. Medical References

Please give the details of any other practitioners, specialists or hospitals that the member has been referred to.

Doctor's Surname

Doctor's First Name(s)

Practice Address

Code

Telephone Number (W)

Email Address

Patient Number

Date referred Y Y Y Y M M D D

Doctor's Surname

Doctor's First Name(s)

Practice Address

Code

Telephone Number (W)

Email Address

Patient Number

Date referred Y Y Y Y M M D D

Doctor's Surname

Doctor's First Name(s)

Practice Address

Code

Telephone Number (W)

Email Address

Patient Number

Date referred Y Y Y Y M M D D

## Section 5. Medical References (Continued)

Doctor's Surname

Doctor's First Name(s)

Practice Address

Code

Telephone Number (W)

Email Address

Patient Number

Date referred Y Y Y Y M M D D

## Section 6. Dread Disease Details

What illness/impairment has led to this claim?

| | | | | | |
|---|---|---|---|---|---|
| Heart Attack | ☐ | Aorta Graft Surgery | ☐ | HIV from Blood Transfusion | ☐ |
| Stroke | ☐ | Alzheimer's Disease | ☐ | Loss of Speech | ☐ |
| Cancer | ☐ | Blindness | ☐ | Benign Brain Tumour | ☐ |
| Major Burns | ☐ | Major Organ Transplant | ☐ | Multiple Sclerosis | ☐ |
| Parkinson's Disease | ☐ | Loss of Limbs | ☐ | Occupational Acquired HIV | ☐ |
| Heart Valve Surgery Graft | ☐ | Motor Neuron Diseases | ☐ | Deafness | ☐ |
| Coronary Artery Bypass Graft | ☐ | Kidney Failure | ☐ | Coma | ☐ |

Date of onset of illness/event or injury claimed for Y Y Y Y M M D D

Date of diagnosis Y Y Y Y M M D D

Please mention any other illness or injury for which the member consulted you.

| Complaint | Date | Degree of Severity |
|---|---|---|
| | Y Y Y Y M M D D | |
| | Y Y Y Y M M D D | |
| | Y Y Y Y M M D D | |
| | Y Y Y Y M M D D | |

Describe fully the cause of the illness/event/injury being claimed for.

Please give details of the member's treatment (including dose and date/duration). Refer to medication, surgery, hospitalisation, rehabilitation etc.)

Please provide all the relevant medical information substantiating the member's condition. Documentation (as per Addendum 1) substantiating the claim is also required, if applicable.

| |
|---|
| |
| |
| |
| |

## Section 7. Supporting Documents Required

Included medical information and specialist reports as per Addendum 1 Yes ☐ No ☐

Included all relevant clinical / diagnostic test results Yes ☐ No ☐

## Section 8. Addendum 1

**Core conditions (assessed under the ASISA standard definitions)**

| | |
|---|---|
| **Cancer** | A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma. |
| Report and Documentation Required | Oncologist's report with histology |
| **Heart Attack** | The death of heart muscle, due to inadequate blood supply as diagnosed by compatible clinical symptoms, characteristics ECG changes of myocardial infarction and raised cardiac markers. |
| Report and Documentation Required | Cardiologist's report with copies of cardiac marker results and ECG |
| **Stroke** | The death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist (refer to attached Addendum 2) |
| Report and Documentation Required | Neurologist's report with copies of neuro-imaging investigative reports and Addendum 2 or WPI rating 3 months post stroke |
| **Coronary Artery Bypass Graft** | Undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary artery/arteries by means of a bypass graft |
| Report and Documentation Required | Surgery report and pre-operative angiogram report |

**Other conditions (assessed under the ASISA standard definitions)**

| **Dread Disease Conditions** | **Report and Documentation Required** |
|---|---|
| Heart valve surgery | Surgery report |
| Aorta graft surgery | Surgery report and pre-operative assessment by specialist surgeon |
| Angioplasty | Per-operative angiography report with surgery report |
| Kidney failure | Nephrologist's report confirming need for permanent dialysis and/or transplant with supporting renal function report |
| Major organ transplant | Surgery report confirming that the transplant has been performed or transplant centre report confirming that the member is on the transplant waiting list. |
| Loss of limbs | Surgeon's report of severance (detailing cause and location of severance) or neurologist's report of loss of function (detailing cause, location and degree of loss of function) |

## Section 8. Addendum 1 (Continue)

| Dread Disease Conditions | Report and Documentation Required |
|---|---|
| Loss of limbs | Surgeon's report of severance (detailing cause and location of severance) or neurologist's report of loss of function (detailing cause, location and degree of loss of function) |
| Blindness | Ophthalmologist's report confirming the degree and permanence of visual impairment in one or both eyes. Corrected visual acuity readings for both eyes too be included. |
| Loss of hearing | Audiologist's report or ENT surgeon's report detailing degree and permanence of hearing loss with audiometric and sound threshold test results for both ears |
| Loss of speech | Specialist report detailing the cause, extent and duration of loss of speech |
| Coma | Neurologist report detailing the nature, extent, duration and permanence of neurological deficits as well as duration of coma |
| Multiple sclerosis | CT scan or MRI scan report and neurologist's report to be completed no sooner than six months after first diagnosis which should detail functional abilities and impairment, specifically commenting on member's mobility and paralysis (extent, degree and location of paralysis) |
| Motor neuron disease | Neurologist's report confirming presence of diagnostic criteria and detailing the extent and permanence of damage to the nervous system |
| Parkinson's disease | Neurologist's report detailing signs of progressive impairment and ability to control the condition with medication. The Neurologist should comment on the members ability to perform the following activities of daily living: transfer, mobility, continence, dressing, bathing/washing, eating |
| Benign brain tumour | CT scan or MRI report with Neurologist's report including comment on presence of clinical symptoms of raised intracranial pressure as well as degree and permanence of the following neurological deficits: blindness, deafness, speech disorder, or motor paralysis involving one or more limbs. |
| Advance dementia (including Alzheimer's disease) | Psychiatrist's or neurologist's report confirming diagnosis and presence of diagnostic criteria and including comment on member's mental and social functioning |
| Acquisition of HIV from blood transfusion | Physician's report including pathology and report confirming liability of acquisition from blood transfusion |
| Occupationally acquired HIV | Occupational medical practitioner report detailing mechanism of and events leading to infection together with pathology reports within 5 days of infection and within 4 (four) months of infection |

## Section 9. Addendum 2

Ability to perform Activities of Daily Living (for stroke). To be completed after 3 months following the date of diagnosis.

| Basic | Competent | Impaired |
|---|---|---|
| Bowel status | | |
| Bladder status | | |
| Grooming | | |
| Toiling | | |
| Feeding | | |
| Transfer from chair to bed | | |
| Indoor mobility | | |
| Dressing | | |
| Stairs | | |
| Bathing | | |

## Section 9. Addendum 2 (Continue)

| Advanced | Competent | Impaired |
|---|---|---|
| Driving a car | | |
| Medical care: prepares and takes correct medication | | |
| Money management | | |
| Communicative activities: use of phone, writing, cheques, writing letters | | |
| Shopping: lifting or carrying groceries | | |
| Food preparation | | |
| Housework | | |
| Community ambulation with or without assistive device, but not requiring a mobility device | | |
| Moderate activities: moving table, pushing vacuum cleaner, bowling, golf | | |
| Vigorous activities: running, heavy lifting, sports | | |

## Section 10. Declaration

I, ___________________________________________________________________________, hereby declare that I have personally examined and attended to the claimant and that the contents of this report are true and correct.

Signed at ____________________________________________________________ on

| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

Signature

Doctor's Stamp

## Section 11. POPIA Consent Clause – CMA Claims

Processing Information in terms of the Protection of Personal Information Act 4 of 2013

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 this disability 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 Application 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.

Signed at ______________________________________________________ on | Y | Y | Y | Y | M | M | D | D |

Signature [ ]