employeebenefits@triarc.co.za | www.triarc.co.za
Phone: 087 231 0222 | Fax: 086 235 5238
Unit 122 The Quays, Park Lane
Century City, 7441

TRIARC is an authorised financial services provider FSP45009

Group Risk Disability Benefit Claim Form - Medical Report

How to complete this form

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.

Completed medical report can be emailed to medicaluw@triarc.co.za .

1. Health Professional Details

Surname

First Names

Qualifications / Specialty

Other Qualifications

Practice Number

HPCSA Registration Number

E-mail Address

Practice Address

Code

Telephone Number

Fax Number

E-mail Address

2. Details of Claimant

Surname

First Names

Date of Birth

Y Y Y Y M M D D

ID Number

Country of Origin

Hospital or File Number

Name of Employer

Telephone Number

Cellphone Number

3. Medical History

Are you treating the claimant for the impairment that gave rise to this claim? ☐ Yes ☐ No

Date of First Consultation Y Y Y Y M M D D

Date of your first consultation with regard to the current symptomology Y Y Y Y M M D D

History of Dates and Reasons for consultations

Dates	Reasons
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	
Y Y Y Y M M D D	
Y Y Y Y M M D D	

How frequently do you see the member (eg. once a month)

3. Medical History (Continued)

Please give details of diagnosis of the illness/accidents for which you have attended since the member was referred to you?

Dates	Diagnosis
Y Y Y Y M M D D	
Y Y Y Y M M D D	
Y Y Y Y M M D D	

What are the co-morbid and underlying conditions?

When did the first symptoms appear? Y Y Y Y M M D D

Has the claimant ever been treated for a similar conditions, or any other medical condition that may have contributed to this impairment? Yes No

If Yes, please supply details:

Do you have the results and reports of special investigations for example histology reports, CD4 Count results, blood tests, x-ray reports, ECG, EEG, MRI scan reports, etc? Yes No

If Yes, please include the copies of these as well as copies of any other reports on file relating to this impairment.

Other health professionals the claimant has been referred to for this and any other conditions:

Please provide names, dates and contact details

Doctor / Specialist / Hospital

Date	Contact Number
Y Y Y Y M M D D	

Doctor / Specialist / Hospital

Date	Contact Number
Y Y Y Y M M D D	

3. Medical History (Continued)

Doctor / Specialist / Hospital

Date Y Y Y Y M M D D

Contact Number

Doctor / Specialist / Hospital

Date Y Y Y Y M M D D

Contact Number

Doctor / Specialist / Hospital

Date Y Y Y Y M M D D

Contact Number

What are the complications the claimant has suffered?

Have any of the following contributed to claimant's condition?

Abuse of ethanol, alcohol or drugs (legal and illegal)	Yes	No
Attempted suicide	Yes	No
War, riot and terrorism	Yes	No
Participation in hazardous sports or leisure pursuits	Yes	No

If Yes to any of the above please provide the details:

Has the claimant ever been tested for or received medical counselling, advice or treatment in connection with any sexually transmitted diseases, including Hepatitis B or HIV-related conditions? Yes No

If Yes, please supply details:

Please elaborate on any family history which may have led to the claimant's condition:

4. Current Medical Status

Current major complaints

Please provide a brief history of the claimant's condition

Describe fully the claimant's current symptoms

Please give full clinical and objective evidence for example general look, height, weight, blood pressure, heart sounds about the claimant's current health, symptoms and impairments

Corrected visual acuity

Limitations evident at the examination (eg. Range of movement, mental state, etc.)

Describe in detail the nature and extent of the member's impairment

4. Current Medical Status (Continued)

Clinical details indicating severity and permanence

Provide the outcome of any other specialist consultations, if applicable. Please enclose copies of available specialist medical reports

Give dates and outcome of any test/ investigations done to diagnose/quantify the member's condition. Please enclose copies of any reports/ investigations done.

For psychiatric claims, please provide the DSM IV 5 Axis diagnosis	
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	

For psychiatric claims, please provide details and comment on any family history of mental illness.

For psychiatric claims, please provide the clinical examination/ mental state examination findings. Please record general appearance, mood, anxiety, psychotic features, mental state, cognitive and social functioning etc.

For psychiatric claims, please provide the results of any bedside cognitive assessments (eg but not limited to MMSE)

4. Current Medical Status (Continued)

Treatment and Rehabilitation:

Please describe the previous and current treatment that the member has/is receiving for his/her condition. Please include names, dosage and dates/duration of all medication.

Medicine			**Dosage**
Start Date	**End Date**	**Period**	
Y Y Y Y M M D D	- Y Y Y Y M M D D	**Current** ☐	**Previous** ☐

Medicine			**Dosage**
Start Date	**End Date**	**Period**	
Y Y Y Y M M D D	- Y Y Y Y M M D D	**Current** ☐	**Previous** ☐

Medicine			**Dosage**
Start Date	**End Date**	**Period**	
Y Y Y Y M M D D	- Y Y Y Y M M D D	**Current** ☐	**Previous** ☐

Medicine			**Dosage**
Start Date	**End Date**	**Period**	
Y Y Y Y M M D D	- Y Y Y Y M M D D	**Current** ☐	**Previous** ☐

Medicine			**Dosage**
Start Date	**End Date**	**Period**	
Y Y Y Y M M D D	- Y Y Y Y M M D D	**Current** ☐	**Previous** ☐

Medicine			**Dosage**
Start Date	**End Date**	**Period**	
Y Y Y Y M M D D	- Y Y Y Y M M D D	**Current** ☐	**Previous** ☐

What is the success rate or effectiveness of the claimant's current treatment?

4. Current Medical Status (Continued)

Are there any other treatment or rehabilitation that the claimant has received or is currently receiving for example: physiotherapy, occupational therapy, psychotherapy etc?

Is there any other treatment, which the claimant could benefit from, but cannot afford or does not have access to? Please comment

Please advise regarding planned future treatment. Refer to medication, surgery, rehabilitation etc. and provide dates

Please provide details of any previous or current hospital admissions. Kindly indicate the date of admission and discharge and reason for admission.

Date of Admission									Date of Discharge							
Y	Y	Y	Y	M	M	D	D		Y	Y	Y	Y	M	M	D	D
Reason for Admission																

Date of Admission									Date of Discharge							
Y	Y	Y	Y	M	M	D	D		Y	Y	Y	Y	M	M	D	D
Reason for Admission																

Date of Admission									Date of Discharge							
Y	Y	Y	Y	M	M	D	D		Y	Y	Y	Y	M	M	D	D
Reason for Admission																

4. Current Medical Status (Continued)

Date of Admission	Date of Discharge
Y Y Y Y M M D D	Y Y Y Y M M D D

Reason for Admission

Date of Admission	Date of Discharge
Y Y Y Y M M D D	Y Y Y Y M M D D

Reason for Admission

Please comment on any occupational therapy assessments, functional assessments or vocational rehabilitation received and the outcome thereof

In your opinion, is the condition one that would benefit from any form of active rehabilitation? ☐ Yes ☐ No

If Yes, please provide suggestions/details of rehabilitation that would be of benefit.

In your opinion is the treatment optimal? ☐ Yes ☐ No

If No, suggest possible alternative therapy, medication, rehabilitation or surgery that may be attempted to maximise management.

4. Current Medical Status (Continued)

Compliance to treatment:

Comment on the member's compliance with treatment (medication, therapy/ rehabilitation, follow up consultations etc.). If not compliant, please advise why not.

Has the condition stabilised or regressed since onset? Please provide substantiating details.

Prognosis:

What are the chances of recovery for example good, fair, poor and nil

Provide the member's short term and long term prognosis with supporting reasons.

In your experience, can you give an indication of the expected recovery period necessary for this member and his/her condition?

Are any residual problems likely?		Yes		No

If Yes, please give details:

Brief details of claimant's current occupation (job title and duties)

4. Current Medical Status (Continued)

In your opinion what was the last date that the member was actively able to work?	Y	Y	Y	Y	M	M	D	D

Please specify why, in your opinion, the member is finding it difficult to perform his/her current occupation and which specific functions of his/her occupation he/she cannot perform?

When is the member expected to be able to return to work?	Y	Y	Y	Y	M	M	D	D

Functional Limitations or Abilities:

Please comment on the claimant's current and expected future ability to carry out specified activities in the below table:

Activity	Current Limitations				Expected Future Ability		
	No Limitation	Partial Limitation	Impossible	Danger to self or others	Improve	Remain Constant	Deteriorate
Seated/Sedentary Tasks							
Clerical/Administrative tasks							
Management and making decisions							
Interacting with others							
Supervising others							
Walking on level terrain							
Walking on uneven terrain							
Climbing							
Kneeling							
Bending							
Standing							
Lifting							
Pushing and Pulling							

4. Current Medical Status (Continued)

Please comment on the claimant's current and expected future ability to carry out specified activities in the below table:

Activity	Current Limitations				Expected Future Ability		
	No Limitation	Partial Limitation	Impossible	Danger to self or others	Improve	Remain Constant	Deteriorate
Operating light machinery							
Operating heavy machinery							
Working with light weights							
Working with heavy weights							
Light Manual Labour							
Heavy Manual Labour							
Driving							
Use of both hands							
Use of fine co-ordination							
Work in cramped conditions							
Work in dusty environment							
Work in fume environment							

Please provide any general comments which may clarify the responses in the table. If improvements are expected, please indicate the period within which that improvement is anticipated.

4. Current Medical Status (Continued)

Please comment on the claimant's ability to perform activities and daily living and self-care tasks. Advise what is and what is not possible

Comment on the claimant's current daily activity profile i.e. how does the claimant spend his/her time at present?

5. 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	Date
	Y Y Y Y M M D D

Signatory First Name(s) and Surname

Doctor's Stamp	Signature

6. POPIA Consent Clause - CMA Claims

Processing of Personal 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 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.

Signed at	Date
	Y Y Y Y M M D D

Signatory First Name(s) and Surname

Signature