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Application for
Disability Benefit
CONFIDENTIAL MEDICAL REPORT
BY GENERAL PRACTITIONER

FORM 3

Name of Fund:
Employer's Name:
Claimant's Name:

A claim for disability benefits in respect of the abovenamed has been received. It would be appreciated if you could complete this Confidential Medical Report. It is important that this form be completed as fully as possible.

If you are in possession of any reports of previous investigations which would help with the assessment of this claim, please attach copies.

1. DETAILS OF DISABILITY

1.1	For how long have you been the claimant's doctor? (If not the claimant's usual doctor, please indicate)
1.2	When were you first consulted in connection with this disability? _____
1.3	When did you last attend to the claimant? _____
1.4	Was the claimant referred to any other medical practitioner? YES / NO (If "YES" , please provide details)

1.5	Was the claimant hospitalised? YES / NO
	If "YES" , please give full details of when, which hospital(s), treatment and results

3.2 In your opinion, on what date was the claimant last able to fulfil the duties of his/her occupation?

3.3 In your opinion, when will the claimant be able to engage in any part of the stated occupation?

Full-time: _____

Part-time: _____

4. If the claimant has already recovered and returned to work, please give the date of his/her return:

5. When is the claimant likely to follow his/her occupation, similar occupation or some other occupation?

Please give brief details of what occupation, in your opinion, the claimant could follow:

6. In your opinion, is the claimant's life expectancy lowered by the illness/injury? YES / NO

If "YES" , to what extent? _____

7. Have any of the following contributed in any way to the claimant's disability?

	YES	NO
7.1 Previous illness or injury	<input type="checkbox"/>	<input type="checkbox"/>
7.2 Hazardous pastimes or pursuits	<input type="checkbox"/>	<input type="checkbox"/>
7.3 Habits	<input type="checkbox"/>	<input type="checkbox"/>
7.4 Self-inflicted injuries	<input type="checkbox"/>	<input type="checkbox"/>
7.5 Wilful criminal action or wilfull exposure to danger	<input type="checkbox"/>	<input type="checkbox"/>
7.6 Child birth, pregnancy or abortion	<input type="checkbox"/>	<input type="checkbox"/>

If any questions in 7 were answered "YES" , please comment fully:

8. Please provide any additional information which you feel will help in the assesment of this claim.

I certify that I have personally attended to the claimant and that all the above statements are correct to the best of my knowledge.

SIGNATURE OF MEDICAL ATTENDANT

DATE

QUALIFICATIONS: _____

FULL NAMES AND ADDRESS: _____

TELEPHONE NUMBER: _____

NB: If the claimant was not referred to a Specialist for the main cause of disablemant, please complete form 4