



Note: Please attach copies of any recent test results and/or reports.

THE REQUEST FOR COMPLETION OF THIS FORM IN NO WAY CONSTITUTES AN ADMISSION OF LIABILITY BY THE INSURER/TRUSTEES.

Patient's name:

Date of birth: (dd mm yyyy):

Your patient has applied for an insurance benefit and is most anxious that his/her application is attended to as soon as possible.

In order to assess our client's state of health we require your assistance by the completion of the questions below.

1. The following proof of identity has been presented: Please specify:
 ID Document Passport Other

2. Are you the applicant's attending specialist? Yes No

If Yes, how long have you acted in this capacity?

Are you aware of the applicant having consulted any other medical person in the last two years and if so, who and when?

Medical Practitioner	Date	Reason
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

3. How frequently do you see the applicant?

When last did you see the applicant, excluding today.

4. Please give details of the illness or accidents for which you have attended to the applicant since he/she has been referred to you in the last two years.

Illness / Injury	Date	Treatment	Outcome
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



5. When were you first consulted in connection with the current impairment?

6. In your opinion what was the date that the claimant was last actively able to work?

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

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

9. Quantify fully the specific changes in function caused by the applicant's impairment.

10. State whether any of the following contributed to the member's disablement.

Previous illness/injury or personal habits:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Wilful self-injury:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
War or Civil commotion or any actions associated herewith:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If Yes, please confirm fully giving details:

11. Please describe the previous and current treatment (including dosages and duration), that the claimant has received/is receiving for his/her impairment. Refer to medication, hospitalisation, counselling, physiotherapy, etc.



12. In your opinion is the treatment optimal and is the claimant compliant with the recommended treatment? If No, please suggest possible alternative treatments, rehabilitation and operations that may be required/needed.

13. Has the condition stabilised or regressed since onset?

14. The short term and long term prognosis of the condition with supporting reasons:

15. In your experience can you give an indication of the expected recovery period necessary for this applicant.

16. In your opinion is the condition one that will benefit from any form of active rehabilitation? If Yes, your suggestions would be appreciated.

17.1 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?

17.2 What functions can he/she still perform?

17.3 Your medical opinion on the patients ability to perform another occupation or his/her own occupation with reasonable accomodations.



