CONFIDENTIAL MEDICAL REPORT

In respect of a Disability Claim

Dear Doctor
This report is in respect of a disability claim that has been submitted by this patient. Please do not under any circumstances show the claimant your report without first consulting with the fund. The report should be faxed to S.A Quantum Consultants and Actuaries on 086 680 9006 and a hard copy must be posted to P.O Box 781687, Sandton 2146. Please retain a copy for your records. Thank you for your assistance in this matter.

1. Medical Practitioners Details

Name: .....Qualifications/Speciality.....

Work postal address: .....

Telephone number ( ) .....Fax number ( ) .....

2. Claimant's Details

Full name: .....

Identity number: .....

Industry number: .....

Company number: .....

3. Consultation History

Date of your first ever consultation with Claimant: .....

Date of your first consultation with regards to the current symptomatology: .....

Date of your last consultation with the claimant: .....

4. Medical References

Please give the details and any other Practitioners, Specialists or Hospitals to whom the Claimant has been referred. Please include copies of all available Specialist reports.

Name of Practitioner/Hospital			
Speciality			
Postal address			
Complaints referred for			

5. Medical History

Please give a full history, including the following:

- Symptoms and diagnoses
- Dates of any diagnoses
- Clinical details indicating severity and permanence
- Relevant test results (e.g. CD4 count, HIV result, lung function readings, X-ray or scan results)
- Treatment and response
- Comments on compliance

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Current major complaint(s):

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6. Results of most recent examination

Date of Examination:.....
Please give full clinical details as at that examination, including height, weight and blood pressure readings. Please include details of any limitations evident at that examination (e.g. joint limitations, visual acuity)

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7. Prognosis

What are the chances of recovery (good/fair/poor/nil)? .....
Are any residual problems likely? ***Please specify***

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8. FUNCTIONAL ABILITIES

Please comment on the member's ability to carry out the specified activities in the table below:

Activity	Current limitations				Expected future ability		
	No limitations	Partial limitations	Impossible	Danger to self or others	Improve	Remain constant	Deteriorate
Seated/sedentary tasks							
Clerical/administrative tasks							
Thinking clearly & making decisions							
Interacting with others							
Supervising other							
Walking (non-strenous) over level ground							
Walking (strenuous) over uneven ground							
Climbing							
Kneeling							
Standing							
Bending							
Operating light machinery							
Operating heavy machinery							
Working with heavy weights							
Working with light weights							
Driving a light motor vehicle							
Light manual labour							
Heavy manual labour							
Use both hands							
Use of fine coordination							
Work in cramped conditions							
Work in dusty environments							
Work in a fume environment							

General comments which may clarify the responses in the table. If improvement is expected, please indicate the time period in which that improvement is anticipated:

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9. Treatment and Rehabilitation

Current medication regime. ***Please specify all medications and dosages.***

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Other treatment the claimant has received or is currently receiving (e.g. physiotherapy, occupational therapy, psychotherapy)

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Planned future treatment, including surgery:

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Your recommendations regarding rehabilitation (if applicable):

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Please attach copies of any correspondence received from Practitioners, Specialists or Hospitals in respect of the claimant.

DECLARATION

I hereby declare that I have personally examined ad attended to the claimant and that the content of this report are true and correct.

....

SIGNED **DATE**

EMPLOYEE'S DECLARATION

In respect of a disability claim

This document is to be completed and signed by the member wishing to apply for disability benefits. The declaration will be used to assess your claim. Please ensure that all questions are answered, and that the information is complete and accurate. Any misstatement may be used as the basis for the claim not to be admitted

1. Employer details

Name of employer:.....

Participation date:.....

Address:.....

Telephone number:( ).....Fax number: ( ).....

Contact Person: .....

2. Personal Details:

Full Name:.....

Identity Number:.....Date of Birth:.....

Gender..... Entry date: .....

Residential Address:.....

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Postal Address:.....

Home / Cell Number: ( ).....Work Number:.....

Income tax number:.....Income Tax Office:.....

Medical aid scheme: .....Medical aid no: .....

3. Education Details:

3.1. Name of last school attended:.....

3.2. Highest Standard Passed: Passed:.....

3.3. Name(s) of universities, colleges or technikons attended:.....

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3.4. Degrees and/or certificates obtained and/or courses passed:.....

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Trade certificates obtained: .....

In-house training received: .....

Codes of any driver's licenses: .....

4. Employment History:

4.1. Please indicate any previous employment, from your recent to your least recent position.

	Most recent			**Earliest position**
Date Started				
Name of Employer				
Job Title				
Broad description of work done				
Date ceased				

Salary at date of leaving				
Details of any commission bonus, overtime etc.				

4.2. When was the last day you were able to fulfill all the normal duties of your job:.....

4.3. What alternative occupation(s) do you consider yourself qualified for by education, training and experience?

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4.4. When do you expect to take up any job in the future:
Please indicate full or part-time, and the nature of the job

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4.5. What is your current employment status?
Please tick relevant box

Employment Status	√
Working Full Time	
Working Part Time	
On Sick Leave	
On Unpaid Leave	
Laid off or Retrenched	
Dismissed	

5. Banking Details:

Bank:.....Branch Code:.....

Bank Account Number:.....Account Type:.....

6. Medical Information:

6.1. List of complains .....

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6.2. State the date and details of your accident/injury/illness:.....

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6.3. Please describe your symptoms:.....

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6.4. Details of any hospitalizations within the past two years:

Name of hospital			
Date of admission			
Date of discharge			

6.5. Details of any surgery performed in the past ten years:.....

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6.6. Your hospital numbers pertaining to any hospitals you have attended for treatment:

Name of hospital			
Hospital number			

6.7. Please state all medication you are currently receiving including the dosage:.....

7. Details of Medical Practitioners:

Please state the details of the medical practitioners currently attending to you.

7.1. General Practitioner:

Name of practitioner:.....

Date First Seen:.....Telephone Number:( ).....

Fax Number:( ).....Postal Address:.....

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7.2. Specialist:

Name of specialist:.....

Date First Seen:.....Telephone Number:( ).....

Fax Number:( ).....Postal Address:.....

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7.3. Specialist:

Name of specialist:.....

Date First Seen:.....Telephone Number:( ).....

Fax Number:( ).....Postal Address:.....

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8. Income details

8.1. Income prior to your impairment:

Normal salary or wagers per month	Bonus or overtime (p.m. average last year)	Commission (p.m. average last year)	Other

8.2. Current or expected future income:

Source of income e.g. Employer, self-employment, insurer, UIF			
Amount of income			
How payable (Monthly, lump sum)			
Date of commencement of payment			
Policy number(s) (if applicable)			

DECLARATION

I declare that all the particulars given on this claim form are to the best of my knowledge true and correct, and that no material information has been withheld or omitted.

I hereby authorise any medical practitioner, hospital or any other person who has information about my health to provide such information to SA Quantum or any interested party nominated by SA Quantum who requires this information for the purposes of assessing my claim.

I hereby authorise SA Quantum to furnish any medical information contained in medical reports or otherwise which they have obtained during the course of the assessment of my claim to any medical practitioner or allied medical practitioner who may require such information for the purpose of assisting SA Quantum in the assessment of my claim.

I hereby consent to and authorize SA Quantum to disclose information related to my medical and functional status, to trustees of the fund and persons related to the assessment of my claim, as deemed necessary for the purposes of making a recommendation in respect of my claim for disability benefits.

Claimants Signature:.....

Witness:.....

Date:.....