PPS OCCUPATIONAL AND QUALITY OF LIFE QUESTIONNAIRE NAMIBIA

INSURANCE NAMIBIA

The Professional Provident Society Holdings Trust No IT 312/2011(PPS Holdings Trust) is a Registered South Africa Trust
Professional Provident Society Insurance Company Limited Reg No. 2001/017730/06 ("PPS Insurance")
Professional Provident Society Insurance Company (Namibia) Limited Reg. No. 2003/122 ("PPS Insurance (Namibia)") – PPS Insurance is an Administrator of PPS Insurance (Namibia).

NOTE: Accuracy is important, not only to enable PPS Insurance (Namibia) to process your claim, but to do so in the shortest time. Please complete this form, giving as much detail as possible.

ALL QUESTIONS MUST BE COMPLETED:

PART A: MEMBER DETAILS

Member Number: National ID Number:

Surname: Initials:

Email:

Cellular:

PART B: OCCUPATIONAL DETAILS PRIOR TO INCAPACITY

1. Were you employed: Full time: ☐ Part-time: ☐ Private Practice: ☐

2. If employed either "full time" or "part time", please provide the following information:

2.1 Name of Institution/Company: ______

2.2 Position held: ______

2.3 Employment start date: ______ End date: ______

2.4 Reason for termination of employment:

3. Have you been medically boarded?
If yes, please provide the following:

Date boarded: ______

Name and contact details of person in charge of the boarding process:

4. Please provide a percentage indication of your normal professional activities, prior to your illness/disability..

Percentage of daily Occupational Activities to be completed by self and salary employed applicants										
Driving as an integral part of your professional duties	Walking on even terrain	Walking on uneven terrain	Climbing ladders, stairs, scaffoldings, etc.	Bending knees / Squatting/ Stooping,etc.	Use of both hands as an integral part of your professional duties (excluding typing and administration)	Fine coordination (e.g. dentistry, surgery, etc.)	Sitting including for administrative purposes	Lifting objects >20kg	Other (Please specify)	Total
%	%	%	%	%	%	%	%	%	%	100%

PART C: CURRENT OCCUPATION DETAILS

1.1 Please state whether your surgery/ rooms/ administrative offices are: still open ☐ closed ☐

Date closed: _____

1.2 If still open, provide details of who is running your surgery/rooms or administrative offices?

Name: _____

Contact number: _____ Brief description of role/responsibilities: _____

2. List your current occupational duties/your involvement in your practice:

3. Please select your current working status and indicate the number of hours worked per day:

		Tick	Hours worked per day
1	Not working		
2	Full time in own occupation		
3	Full time in similar occupation		
4	Full time in unrelated occupation		
5	Part time in own occupation		
6	Part time in similar occupation		
7	Part time in unrelated occupation		

4. How do you occupy your day (without professional activities)?

5. What discomfort/ difficulty do you still experience which prevents you from practicing your professional duties at the same capacity as prior to your illness/injury illness?

6. What adaptations do you require in order to carry out your occupational duties at the same capacity as prior to your illness/injury? Adaptations mean any alterations or adjustments to work environment (e.g. small adjustment to your working hours and workload or adjustments to your work area), which makes carrying out your occupational duties easier or possible:

7. Describe the occupational activities that you are **able** to carry out **now** even if you are not currently working or have retired:

8. Provide details regarding your: Gross Professional Income: Currently: N$ _____

Before illness/disability: N$ _____

9. When do you hope to return to a meaningful, supportive, income-generating employment?

PART D: TREATMENT DETAILS

1. Please list the medical doctor/s and all allied medical practitioners (physiotherapist or occupational therapist) involved in your treatment?

Surname and Initials	Phone number	Email Address	Speciality	Date last consulted

2. How regularly do you consult your doctor (e.g. once a month, weekly, etc.)? _____

3. Please indicate what other treatment or therapy you have received for your disability/sickness:

	Once	Twice	Thrice	Date of last treatment
Surgery				
Therapy e.g. physiotherapy				
Radiotherapy				
Chemotherapy				
Counselling				
Other				

4a. Are you currently on any medication? Y ☐ N ☐

4b. Please list the medication, dose and frequency:

Name of medication	Dose	Frequency

4c. Are you experiencing any side effects from this medication? Y ☐ N ☐

If yes, provide comprehensive details:

5. Has your doctor suggested any other form of treatment (surgery, occupational therapy, return to work program)? Y ☐ N ☐

If yes, has it been implemented? Y ☐ N ☐

If yes, what treatment has the doctor suggested and provide the date when started:

Kindly provide the name and contact details of the doctor/therapist who is responsible for the above:

If no, please provide reasons:

PART E: QUALITY OF LIFE DETAILS

NOTE: Rate the questions on a scale from 1-10 (1) being normal to (10) being severe. If your rating is 4 or greater, please explain how it has impacted the specific area in the space provided.

1. Your usual routine daily activities e.g. bathing, dressing. (scale from 1-10) ☐

2. Were you able to drive a motor vehicle before your impairment? Y ☐ N ☐

   If so, to what extent does your sickness/disability impede this function now? (scale from 1-10) ☐

3. Prior to your incapacity, did you do any shopping, household chores or maintenance? Y ☐ N ☐

   If so, kindly provide details as to your current involvement in these activities. (scale from 1-10) ☐

4. Are you suffering from any pain? Y ☐ N ☐

   If so, please rate the severity of the pain that you are suffering. (scale from 1-10) ☐

5. Do you sleep well? Y ☐ N ☐

   If no, please rate the deterioration of your normal sleep pattern. (scale from 1-10) ☐

6.1 Indicate to what degree concentration impairment has affected your daily living. (Scale from 1-10) ☐

6.2 Indicate to what degree memory impairment/forgetfulness has affected your daily living. (Scale from 1-10) ☐

7. Have you experienced any loss of self-confidence or self-esteem due to your impairment? Y ☐ N ☐

Please rate the extent to which you are affected (scale from 1-10) ☐

8. Before your incapacity, did you socialise with family/ friends/ colleagues? Y ☐ N ☐

Please rate how much your social life has been affected by your incapacity. (scale from 1-10) ☐

9. Please explain how your house has been adapted to accommodate your condition/disability. E.g. (any railings, ramps etc.):

10. Please indicate your level (e.g. seldom, often, frequent) of participation in these non-professional activities:

	Before Incapacity	After Incapacity
Tennis		
Squash		
Golf		
Hiking		
Walking		
Jogging		
Gardening		
Reading		
Visiting		
Socialising		
Other		

11a. Are you registered with a statutory body? Y ☐ N ☐

11b. If yes, please indicate your registration number _____

11c If not registered, provide the date deregistered _____ and reason/s _____

12. Do you handle your own personal finances? Y ☐ N ☐

If your answer is No, please give reasons _____

13. What do you consider as your two (2) most disabling symptoms?

14. What emotional/ psychological effects are you experiencing as a result of your impairments?

15. Have you submitted a claim for disability benefits with another company for this same condition/illness. Y ☐ N ☐

If yes, please provide the name of the company: _____

Contact person name and surname: _____

Contact details: _____

I certify that all the above information is correct.

Signature of policyholder: _____

Signed at _____ this _____ day of _____ 20 ☐

Did you require assistance when completing this form? Y ☐ N ☐

If yes, please provide details of the person that assisted you:

Name of person: _____ Signature: _____

Relationship: _____