



### 3. HOSPITALISATION

Only complete if you were hospitalised:

a. Name of hospital:

Date admitted:  /  /

Date discharged:  /  /

b. Name of hospital:

Date admitted:  /  /

Date discharged:  /  /

### PART C: MEDICAL PARTICULARS OF CLAIM

1. Please state the medical condition for which you are claiming for:

2. The nature of most psychological conditions is that it develops over time and may be the result of an incident/s. Please provide brief details of the chronological history (date of onset, progression up to now and date of final diagnosis) of your condition:

3. To form a holistic view of your condition our claims area may find it necessary to obtain further medical information. Please state the name(s) of the Psychiatrists, Psychologists and any other therapists or doctors whom attended to you since you first experienced the symptoms up to now:

Practitioner's Surname & Initials	Speciality	Latest consultation date	Telephone number or E-mail address

4. Please state which practitioner declared you incapacitated and how often you consult your doctor.

5. Please list the investigations (blood tests, scans or specialist assessments, etc.), that you have undergone up to now.

6. The treatment of psychological conditions often incorporates multiple types of therapy. Please provide details of treatment received to date:

Treatment	Commencement date	Date of completion	Details (Dose/ frequency of consultations, number of sessions)
Pharmacotherapy (medication)			
Psychotherapy			
Electroconvulsive therapy			
Other			

7. Some people that use psychotropic medication may experience side effects. The effect of side effects can however be limited. If you do experience side effects describe the nature of the side effects and discuss measures that have been implemented to limit the effect thereof on your functioning:

**PART D: OCCUPATIONAL DETAILS**

1. Please state the following regarding your occupation:

a) Current occupation:

b) Commencement date of occupation:

c) If you are not currently employed, provide details including reasons and dates:

d) Give a full description of the duties you performed prior to this claim:

e) Describe how your condition impacts your ability to perform your usual professional duties?

f) Some people with mental health conditions find that they are able, with minor accommodations, to work in the same way they did before. Has a return to work program been discussed with you by treating doctor/specialist? YES  NO

If yes, provide brief details regarding the program. If no kindly advise why this has not yet been considered:

2. If you are required to register with a statutory body/ professional association, please provide the following:

a) Name of statutory body or authority:

b) Registration number:

c) If not registered, provide the date of deregistration:   /   /

**PART E: SELF EMPLOYED (only complete if self - employed)**

State the name of your practice/business

If you are a partner in the business, what is your percentage share?

Where is the business located: Home  Private premises

**Gross Professional Income** (Annual income from professional fees and nett income from trading activities; including all overhead expenses):

**(Minus) Actual Expenses** (Expenses incurred in the running of the business that are not remunerated to the professional. Expenses that will terminate if the business is sold or closed):

**(Equals) Personal Income** (Gross Professional Income minus Actual Expenses):

**PART F: SALARIED EMPLOYED (only complete if in salaried employment)**

State the name of your employer

**Annual Total Cost to Company** (Annual salary plus all fringe benefits):

**Plus Performance Bonus** (Average over the last 3 years)

**Equals Total Gross** (Professional income)

**PART G: WHAT IS THE SOURCE OF THE FUNDS BEING USED TO PAY THE PREMIUMS FOR THIS PRODUCT: PLEASE TICK THE MOST APPROPRIATE OPTION.**

Salary/ Income generated from occupation:

Trust:

Investments:

Other; please specify

**PART H: ACTIVITIES OF DAILY LIVING**

1. Conditions affect people in different ways. Please describe how your condition affects your functioning in the following areas:

Concentration, memory/attention	
Speech	
Interpersonal relations	
Self-care activities (e.g. bathing, dressing etc)	
Sleep	
Writing	
Driving	
Shopping/Finances	
Sport	

2. Please provide a brief description of how you occupied your day during the above sickness period:

**PART I: BANKING DETAILS FOR SICKNESS BENEFIT VIA EFT** (Only complete when payment is to be made into a bank account other than from which premiums are collected)

(Please attach a cancelled cheque or bank statement stamped by the bank)

Name of account holder:

Name of bank:

Account number:

Branch code:

Type of account: Current  Savings  Cheque  Transmission

Indemnity – Please take note that PPS will not be held liable for incorrect payments, if the information received is incorrect

**PART J: DECLARATION**

I specifically authorise PPS Insurance to communicate any requirements to my financial advisor which may entail providing information regarding my current medical condition: YES  NO

Financial Advisor's Name:

Email:

I authorise PPS Insurance to:

- a. Access any information which it deems necessary to assess any insurance risk or to consider a claim and I understand that if I choose not to provide this information PPS will not be able to assess my claim for insurance.
- b. Share with other insurers and their representation body any information in the possession of PPS Insurance, either directly or through a database operated by, or for insurers as a group and authorise PPS to also collect my personal information from other insurers as exchange of information helps to waive costs and combat fraud. PPS Insurance (Namibia) can further process any such information in accordance or compatible with the purpose for which it was collected.
- c. Disclose any information to the PPS Holdings Trust, subsidiaries, affiliates, Profmed or other persons provided that it is necessary to properly underwrite, manage, assess the claim or service the policy, policy assets or myself. PPS Insurance may be required to disclose your information to regulatory or government agencies.
- d. Obtain credit information from any person or institution.

AND

I understand that I can request details of the information held by my insurer and request its correction where appropriate.

AND

I authorise a doctor, hospital, medical aid or any other person to provide this information to PPS.

PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS will adhere to any laws governing the protection of (and access to) personal information and will not use your information for any purpose not provided for in your Policy Contract and in this Part II.

Signed at (Place)  on this  day of  20

Signature of member

## INFORMATION REGARDING THE SUBMISSION OF SICKNESS CLAIMS

The payment of sickness benefits is subject to certain claim procedures. To ensure a timeous and complete assessment of your claim you and your treating Psychiatrist are required to answer all the questions in full. Incomplete information will delay the assessment of your claim and may result in additional costs for you.

For more information, please find the "How to claim" document in the FAQ tab on [www.pps.com.na](http://www.pps.com.na)

Two forms (A and B) must be submitted before a claim can be processed:

### A. Declaration by Psychiatrist

1. Your treating Psychiatrist must complete this form.
2. Please note that whilst PPS values the contribution of Psychologists, Physiotherapists and Occupational therapists in the treatment of patients, only medical doctors may book PPS members off work for PPS benefits.
3. The initial consultation date must be within the first 7 days of the start of the claim period. The most recent consultation dates should be stated.
4. To avoid conflict of interest, Declaration by Psychiatrist Forms are only accepted from independent Psychiatrist where there is no familial or other relationship between the physician and the policyholder except for the doctor/patient relationship. Where this is not the case PPS reserves the right to ask for any additional medical or other information that it may deem necessary to validate the claim.

### B. Declaration by Member

1. You must complete this form.
2. All claim periods should be accompanied by a form from the doctor whom attended to you and booked you off for the period.
3. Post-dated claim forms are not accepted. A claim will only be assessed up to the date signed if it was signed at least 7 days after the start date of the claim period. To ensure regular processing of continuous claims we urge you to submit claims monthly.
4. If an accident is the cause of your claim, you must provide us with details on how the accident occurred.

### C. General

1. **Standard recovery period:** PPS will assess sickness claims based on the expected standard recovery time for a health condition. The 'standard recovery period' paid for a condition is based on standard medical practice. Should further recuperation time be required due to e.g. complications, the reason must be indicated on the Declaration by Psychiatrist form and the likely date for returning to work stated. PPS may require further information from you and/or your treating doctor to holistically assess your claim, should the period extend beyond the expected period. The outcome of claims or need for additional information will be communicated in writing.

2. In order for you to claim **Total benefits** you must not be able to perform any part of the professional duties normally associated with your occupation, whether physical or mental, including minor physical tasks such as consulting, or administrative tasks normally associated with your work. If you can carry out some of your professional duties, even on a very limited scale, you are not allowed to claim Total benefits.

If you are claiming **Partial benefits**, you are considered able to perform some of your work duties. Being partially able to work would include (but is not limited to) performing business critical administrative tasks while recuperating at home; or working for a limited period per day (including overseeing work/ operations of your practice) or consulting a reduced number of patients. PPS reserves the right to assess claims according to international claims standards and current claims practice. Should you be found to be working whilst claiming total benefits, or working full day while claiming partial benefits, you may be prosecuted, and your benefits may be cancelled.

3. The Sickness product has two waiting periods, namely, seven (7) days or thirty (30) days. Thus, depending on the waiting period, you have chosen, the benefit will pay as follows:

**7-day waiting period:** A total Sick Pay Benefit will be considered if you were totally unable to perform any of your usual professional duties for at least seven consecutive days, due to sickness. The benefit will pay from day one. Once this initial requirement for a minimum period of seven consecutive days of total incapacity is met, ongoing claims for the same or consequential condition can be submitted on a continuing total or partial basis.

Should you however not fulfil the criteria of above seven consecutive days, a Sick Pay Benefit will be considered if you are unable, either **totally or partially**, to carry out your usual professional duties for a least 30 consecutive days due to sickness. The Sick Pay Benefit will be paid on either a Total or a Partial basis, whichever is applicable, prospectively from day 31.

**30- day waiting period:** A Sick Pay Benefit will be considered if you are unable, either **totally or partially**, to carry out your usual professional duties for at least 30 consecutive days due to sickness. The Sick Pay Benefit will be paid on either a Total or a Partial basis, whichever is applicable, prospectively from day 31.

**Please refer to your policy certificate to confirm if you have a 7 day or 30 day waiting period benefit.**

4. Claims for benefits in terms of the PPS Provider Policy should be submitted as soon as possible after the occurrence of the event that gave rise to the claim to ensure efficient claims processing. Please note any claims older than six months will not be considered.
5. When approval has been received for submission of an ongoing claim by the long-term claims department, each monthly claim form should be dated from the first date to the last date of the month being claimed, e.g. 1.3.2004 – 31.3.2004 and the following month 1.4.2004 – 30.4.2004.
6. Admission Rider Benefit, where applicable, can only be paid on receipt of the admission sheet or the hospital account showing admission and discharge dates. You will qualify for payment of the Admission Rider Benefit if you were hospitalised for at least four consecutive days.
7. Post-dated claim periods are not accepted.
8. PPS can, in terms of the PPS Provider Policy, request submission of weekly consultations and claim forms if deemed appropriate in the circumstance of a sickness claim. This will be done where the claim management protocol requires weekly follow up.
9. Please allow eight working days before querying the progress of your claim.
10. In some instances, additional information may be requested from either yourself or Psychiatrist. This is especially the case where forms have not been completed fully. Kindly take note that this could delay the finalisation of the claim. You and/or Psychiatrist will be notified by email/fax/post if additional information is required.