PREGNANCY RELATED SICKNESS BENEFIT CLAIM (DECLARATION BY TREATING OBSTETRICIAN/ **GYNAECOLOGIST)**

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



Dear Doctor,

We appreciate your time and cooperation to assist us in considering a Sick Pay benefit claim for your patient.

The following is important:

- PPS Insurance (Namibia) has signed consent from your patient to obtain confidential medical information from you.
- Please attach **all** relevant investigations conducted.
- Please attach all ultrasonography, cardiotocography reports and blood tests that were performed to confirm the diagnosis.
- Any costs to provide this information will be for your patient's account.
- Please send the form and supporting documents to:
 - o Fax: +264 (0)61 411 330 or
 - o E-mail: namibiaclaims@pps.co.za

• Your prompt response will b	е арргесіатец.		
PART A: MEMBER DETAILS			
Member Number: Surname:	Na	tional ID number:	Initials:
PART B: GENERAL CLAIM INFO	RMATION		
1. What was the gestational age a	t time of the complication?		
2. What is the estimated date of d	elivery (expected prior to cor	mplication)? DD / M	M / Y Y Y
3. Please provide the primary obst	etric diagnosis		
4. Date of diagnosis: D D /	M M / Y Y Y Y	Date of onset of symptoms:	D D / M M / Y Y Y Y
5. Date of first consultation:	D / M M / Y Y	Y Y ICD10 code(s):	
6. Please provide brief details of the	ne chronological history of th	e condition, or sequence of e	vents:
7. Details of treatment administere	ed for current illness, or claim	event including medication, b	edrest, physiotherapy and psychotherapy,
	Doses and frequency of treatment	Date commenced	Completion date

8. Provide brief details of any surgical procedure performed for current illness or claim event. Please include any complications of surgery that have occurred
9. Were there any predisposing factors for this condition?
PART C: CLAIM DETAILS
1. TOTAL BENEFITS: The patient was unable to perform ANY professional duties from:
Start date: DD / MM / YYYY End date: DD / MM / YYYY
NOTE To qualify for Total benefits your patient should not be able to perform any of the occupational duties normally associated
with their above occupation, whether physical or mental tasks, including minor physical tasks such as consulting, or administrative tasks such as dealing with queries.
2. PARTIAL BENEFITS: The patient was able to perform SOME Professional duties from:
Start date: D D / M M / Y Y Y End date: D D / M M / Y Y Y
NOTE To qualify for Partial benefits your patient is able to carry out some of their normal occupational duties as above, or work reduced working hours compared to normal working hours, but not all. PPS Claims will also assess this in line with the occupation and profession.
3. When did your patient resume her usual professional duties on a full- time basis? DD / MM M / YYYY
4. If your patient has not returned to work, please indicate the expected return to work date:
Full time: DD / MM / YYYY Part time: DD / MM / YYYY
PART D: TREATING OBSTETRICIAN'S/GYNAECOLOGIST'S DETAILS
HPCNA Reg No Practice No:
Surname: Initials:
Telephone No:
Email address:
Physical Address:
Signed at: day of 20
Signature of Obstetrician/Gynaecologist