

Disability Claim Form Medical Certificate

Evolution Life is a division of OPCO 365 (Pty) Ltd, a registered Financial Services Provider (FSP9945) with Reg. No. 2001/004440/07 and underwritten by Old Mutual Alternative Risk Transfer Limited ("OMART") a licensed Life Insurer
P O Box 19610, Tecoma, 5210

SUBMISSION OF CREDIT LIFE CLAIMS: FACSIMILE 086 623 4234 | HELPDESK: 086 111 4803 | E-MAIL: creditlife@evolution.za.com
SUBMISSION OF CLAIMS FOR OTHER POLICIES: HELPDESK 086 111 4803 | FAX TO 086 623 4080 | E-MAIL realclaims@evolution.za.com



Dear Doctor,

We would appreciate your co-operation in providing the information requested in this form.

Insurance disability has two components i.e. functional impairment and disability. The assessment of functional impairment rests with various medical experts and is aimed at establishing the degree of impairment of normal functions due to medical, psychiatric or traumatic causes after reasonable treatment. It also involves the duration of the impairment, whether it is of permanent nature or temporary, and if temporary the life duration and prognosis.

The decision regarding disability is a legal decision taken by the insurance company and is based on details of the claimant, the occupation for which the claimant is insured, the terms and conditions on which the risk was accepted and the contract issued and the medical impairment of the life assured itself. The information requested, is therefore required to assist us in reaching this decision as quickly as possible.

Thanking you in anticipation.

Yours faithfully,
Evolution Life

A. PATIENT / CLAIMANT DETAILS

Names																											
Surname																											
ID number																											
Home No.														Work No.													
Cell No.														Fax No.													
E-mail address																											

B. MEDICAL AID DETAILS

Name of medical aid																										
Main member																										
Membership number																										

C. MEDICAL HISTORY

Diagnosis and reason for claim

Current major complaint(s)

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D. MEDICAL REFERENCE

Please give the details of any other Practitioner, Specialists or Hospitals to whom the claimant has been referred. Please include copies of all available specialist reports.

Name of Practitioner / Hospital	
Speciality	
Address	
Complaints referred for	
Name of Practitioner / Hospital	
Speciality	
Address	
Complaints referred for	
Name of Practitioner / Hospital	
Speciality	
Address	
Complaints referred for	

E. RESULTS OF MOST RECENT MEDICAL EXAMINATION

Date of examination	D	D	M	M	Y	Y	Y	Y
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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 limitation, visual acuities etc.)

What was the cause of disability?

Date symptoms started	D	D	M	M	Y	Y	Y	Y
Date first seen by you for this reason	D	D	M	M	Y	Y	Y	Y
Date stopped worked	D	D	M	M	Y	Y	Y	Y
Date expected to return to work	D	D	M	M	Y	Y	Y	Y

PLEASE NOTE: That in the event of any modification or variation of this standard form, OMART through Evolution Life will regard this form as being invalid and of no force & effect.

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F. PROGNOSIS

What are the chances of recovery

Good

Fair

Poor

Nil

Does the claimant use tobacco in any form?

Yes

No

If "yes", please provide details

Is current medical impairment due to:

Previous illness or injury

Yes

No

The intentional consumption of alcohol, narcotics or any toxic substance

Yes

No

Attempted suicide or any self-inflicted injury

Yes

No

G. FUNCTIONAL ABILITIES

Activity	Current limitations				Expected future ability		
	No limitation	Partial limitation	Impossible	Danger to self or others	Improve	Remain Constant	Deteriorate
Sealed/sedentary tasks							
Clerical/administrative tasks							
Thinking clearly and making decisions							
Interacting with others							
Walking (non-strenuous) over level ground							
Climbing							
Kneeling							
Standing							
Bending							
Operating light machinery							
Operating heavy machinery							
Working with light machinery							
Driving with light motor vehicle							
Driving with heavy motor vehicle							
Light manual labour							
Use of both arms and legs							
Use of fine coordination							
Work in cramped conditions							
Work in dusty environment							
Work in a fume environment							

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

If period off from work is longer than usually expected for impairment, please give reason

