PPS OCCUPATIONAL OR FUNCTIONAL DISABILITY OR SEVERE ILLNESS CLAIM FORM - MEMBER

NOTE: The PPS Occupational or Functional Disability or Severe Illness - Member claim form will be used to assess benefits under the Occupational Disability, Functional Disability, or Severe Illness benefit, respectively.

Where both the Occupational Disability Benefit and the Functional Disability Benefit (synchronised benefit) have been chosen, claims will first be assessed under the occupational disability definition, and if the claim does not qualify for a benefit, it will then be assessed further under the functional disability definitions.

Please specify the benefit which you are claiming for:

Functional Disability benefit **(Complete Parts A, B, D, E, F below)** ☐

Occupational Disability benefit with or without OSRB **(Complete Parts, A, B, C, D, E, F below)** ☐

Severe Illness benefit **(Complete Parts A, B, E, F below)** ☐

REQUIREMENTS:

In addition to the information listed below, claims should be submitted with the following supporting documents:

- PPS Occupational or Functional Disability or Severe Illness claim form, fully completed by the appropriate specialist.
- Detailed medical attendant report. A guideline for the details required is provided for easy reference on the doctor's claim form.
- All relevant medical, blood and special investigation reports, plus any other relevant documentation confirming/supporting the illness.
- Proof if you have been placed under permanent curatorship by the Master of the High Court in South Africa, where applicable.
- Proof of permanent institutionalisation, where applicable.
- **Proof that you require 24-hour nursing care at a home or in a frail care facility if you wish to be assessed under the Functional Disability-Catch All definition.**

PLEASE NOTE: Reports are to be supplied at the policyholder's own cost.
For more information on the benefit and its severity levels, please refer to the list of claim definitions in your latest Policy Summary, as well as Appendix A and Appendix F of your Provider Policy wording.

Claims submission:

PPS Occupational and Functional Disability claims: Please send the fully completed form and supporting documentation to **PIclaims@pps.co.za.**

PPS Severe Illness claims: Please send the fully completed form and supporting documentation to **claims@pps.co.za.**

Claim-related enquiries:
E: memberservices@pps.co.za
T: 0860 123 777 or +27 (0)10 085 3820
Monday to Friday from 07:00 to 19:00 and Saturday from 08:00 to 13:00

PART A: MEMBER DETAILS

Membership number:

ID/Passport number (if no ID):

First names:

Surname:

Cell phone: Telephone:

E-mail:

Medical aid name: Medical aid number:

PART B: CLAIM DETAILS

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

Date of diagnosis: D D M M Y Y Y Y

Date of onset of symptoms: D D M M Y Y Y Y

Date of first consultation: D D M M Y Y Y Y

2. Provide brief details of the chronological history (date of onset and progression up to now) of the condition:

3. Did the sickness/disability originate outside of South Africa? YES ☐ NO ☐

If YES, specify in which country:

4. Are you currently working or have you retired from your occupation? If retired, kindly elaborate.

PART C: EMPLOYMENT QUESTIONS RELATED TO THE WORK PERFORMED DIRECTLY BEFORE THE ONSET OF THE SICKNESS/DISABILITY AND CURRENTLY

1. Please list all your qualifications:

Qualification	**Year obtained**

1.1 Are you registered with a statutory body? YES ☐ NO ☐

1.2 If YES, please indicate your registration number:

1.3 If NOT registered, provide date of deregistration:

And reason(s) for deregistration:

2. Occupational duties analysis

Please complete the below table as accurately as possible

Job title	
How long have you been in this current position	
Job purpose and responsibilities/functions	
Job requirements	

3. Describe your employment status as accurately as possible before sickness and currently on the table below.

	Before the onset of sickness/disability	**Currently**
Profession		
Job title		
Employment status	Part time: ☐ Self employed: ☐ Full time: ☐ Salary employed: ☐ Unemployed: ☐	Part time: ☐ Self employed: ☐ Full time: ☐ Salary employed: ☐ Unemployed: ☐
If unemployed, select the reasons from the list	Retrenchment: ☐ Resignation: ☐ Contract expired: ☐ Sold private practice/business: ☐ Other (elaborate):	Retrenchment: ☐ Resignation: ☐ Contract expired: ☐ Sold private practice/business: ☐ Other (elaborate):
If unemployed, state the last date of employment and attach proof confirming your reason for unemployment		
Select the option that best reflects your work setting (choose one)	Own occupation: ☐ Similar occupation: ☐ Unrelated Occupation: ☐	Own occupation: ☐ Similar occupation: ☐ Unrelated Occupation: ☐
Name of institution/company		
Employment start date		
Employment end date		
Number of hours worked per day		
Indicate if overtime is required	Over time hours per month:	Over time hours per month:
	Frequency of overtime:	Frequency of overtime:

4. To assess how the sickness has impacted your occupational duties, list the occupational **duties/tasks** you performed **directly before** the onset of the sickness and **duties/tasks** you are **currently performing** indicating the number of hours spent on the relevant activity as part of your week.

Before the onset of illness/disability				**Currently**			
Duty/Task	Time spent	Frequency per week	Task Interdependence	Duty/Task	Time spent	Frequency per week	Task Interdependence
e.g., Surgery	e.g., 7 hours		Consultation with patients	e.g., Surgery	e.g., 7 hours		Consultation with patients
1.				1.			
2.				2.			
3.				3.			
4.				4.			
5.				5.			
6.				6.			
7.				7.			

5. Details of termination/medical boarding/suspension:

5.1 Has your employment been terminated/have you been medically boarded? YES ☐ NO ☐

5.2 Nature of termination/medical boarding/suspension Permanent: ☐ Temporary: ☐

5.3 Reason for termination/medical boarding/suspension

5.4 Termination/medical boarding date: D D M M Y Y Y Y

5.5 Last day actively at work performing usual professional duties: D D M M Y Y Y Y

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

First names:

Surname:

Cellular:

E-mail:

6. If self-employed, please state whether your surgery/rooms or administrative offices are currently: Still open: ☐ Closed: ☐

6.1 If closed, indicate date closed: D D M M Y Y Y Y

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

Name:

Telephone:

6.3 Brief description of the role/responsibility of the person running the business:

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

8. What discomfort/difficulty do you currently experience which prevents you from practising your professional duties at the same capacity as before your sickness/disability?

8.1 List the accommodations or adaptations that have been implemented or explored (since the onset of your sickness/disability) to enable you to carry out all or some of your occupational duties, at the same capacity as before your sickness/disability.

NOTE: Adaptations mean any alterations or adjustments to the 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:

8.2 Indicate which of these adaptations have not been feasible and provide a reason why:

8.3 Contact details (name and phone number) of the person(s) at work that can be contacted about the accommodations made at work:

Name:

Telephone:

PART D: QUALITY OF LIFE DETAILS

Rate to what extent your sickness/disability has affected the following areas in your life:

NOTE: Rate the questions on a scale from 1-10 (1) being no changes 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 daily activities, i.e., bathing, dressing. (scale from 1-10) ☐☐

2. Were you able to drive a motor vehicle before your impairment? YES ☐ NO ☐

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

3. When do you suffer from pain? (e.g., at the end of the day, at nighttime)

4. Describe your sleep quality, pattern and impact on your functioning during the day:

5. Comment on the impact that your sickness/disability has on the following functions:

Function	**Impact due to sickness/disability**
Concentration	
Memory	
Self-confidence/Self-esteem	
Ability to socialise	

6. Has/have there been adaptations/adjustments to your home? YES ☐ NO ☐

6.1 If YES, please give details: (e.g., any railing, ramps):

7. Please indicate your level (e.g., seldom, often, frequent) of participation in non-professional activities, such as tennis, golf, gardening, etc.:

Detail of activity	**Before sickness/disability (seldom/ often/frequent)**	**Currently (seldom/often/frequent)**

8. Do you handle your own personal finances? YES ☐ NO ☐

If your answer is NO, please give reasons:

9. What do you consider your two most disabling symptoms?

10. Have you submitted a claim for disability benefits with another company for this same sickness /disability? YES ☐ NO ☐

If YES, please provide the name of the company:

Contact person's name and surname:

Telephone:

PART E: BANKING DETAILS FOR CLAIM BENEFIT VIA EFT

NOTE Financial governance requires that all benefits regarding claims must be settled to the same account from which your premiums are paid **(premium-paying account)**. Please note that this is an improved security measure to mitigate financial risks for claiming policyholders.

Please provide alternative bank details below if you cannot receive payment to your premium-paying account for any reason.

Changing the account to which claim benefits are paid will require additional diligence and proof.
The required additional diligence will take an additional five working days before payment can be made.

If you must change your banking details, please include the required proof together with this claim form.

I understand this note and request PPS to: *(Select the appropriate option)*

1. Pay any benefits due to my existing premium-paying account. ☐

2. Use the new account details below to pay any benefits due to me. ☐

   2.1. Please update my premium-paying account to the new details below for future premium payments. YES ☐ NO ☐

Name of account holder:

Name of bank:

Account number:

Branch code:

Type of account:

If you have selected option 2 above, please provide PPS with proof of account and certified proof of the account holder's identity. The accepted proof of account is a bank-stamped verification letter on the bank's letterhead not older than three months. PPS cannot make changes to this account without the required proof.

Foreign bank accounts*: Please note that in terms of the PPS Provider™ Policy, premiums from the policyholder should be paid from a South African bank account and benefits to the policyholder should also be paid into a South African bank account, in South African currency. Accordingly, PPS Insurance assumes no responsibility or liability whatsoever in the event the policyholder pays premiums from a foreign bank account, or the policyholder nominates a foreign bank account for receipt of policy benefits. To ensure compliance with South African foreign exchange regulations, policyholders are encouraged to nominate a verified local bank account. Payment into foreign accounts may be declined or delayed pending legal clearance. Policyholders must confirm banking arrangements with PPS prior to submission. Furthermore, any payment to and from PPS Insurance involving a foreign bank shall be at the sole discretion of PPS Insurance and subject to the South African foreign exchange regulations and other relevant legislation as amended from time to time. PPS Insurance assumes no responsibility or liability to inform the policyholder of any changes in such regulations and legislation.*

Indemnity: Please note that PPS will not be held liable for incorrect payments if the account information supplied is incorrect. By signing this form, the policyholder indemnifies PPS and holds PPS harmless against any losses, liabilities, claims, charges, expenses, costs or any other actions or demands of whatever nature, which could or might be suffered or incurred by the policyholder or any third party whether directly or indirectly, caused by and/or arising out of the payment into the above account.

PART F: AUTHORISATION TO COMMUNICATE WITH FINANCIAL ADVISER

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

Financial adviser's name:

Financial adviser's e-mail :

PART G: DECLARATION

The Professional Provident Society (PPS) Holdings Trust No IT 312/2011 is a Registered South African Trust. The Professional Provident Society Insurance Company Limited Reg. No 2001/017730/06 is a licensed insurer conducting life insurance business, a licensed controlling company and an authorised financial services provider. Any reference to PPS in this form means PPS Insurance.

I _____ (member full name and surname) and ID number: _____

authorise PPS Insurance to:

a) Access any information deemed necessary to assess any insurance risk or to consider a claim. I understand that if I choose not to provide this information, PPS will not be able to assess the claim for insurance.

b) Share with other insurers and their representative 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 save costs and combat fraud. PPS 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, PPS Insurance's subsidiaries and affiliates 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 my 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 Insurance.

PPS Insurance will always do its utmost to prevent any unauthorised disclosure of your personal information. PPS Insurance will adhere to any law 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 including any relevant parts thereof such as Part F and Part G.

Signed at _____ this _____ day of _____ 20 _____

Signature of policyholder: _____

DISCLAIMER:

By submitting this form electronically, you acknowledge that your electronic signature holds the same legal weight as a handwritten signature. For authorised electronic signature details, contact your financial adviser or e-mail memberservices@pps.co.za. You accept responsibility for the legitimacy of the submitted electronic signature. PPS will rely on technical audit trails and platform controls to determine responsibility in the event of a signature dispute.