Hollard.

HEART CHART BY PHYSICIAN SPECIALIST

(To be completed by both the life insured and the medical attendant)

Please return this completed form to ds_uwrequirements@hollard.co.za.

1. Life insured's details

Policy no. ______________________ Identity no. ______________________

Name of insured ____

Verification of applicant details

I, ______________________________ (name of medical examiner making this declaration)

employed by ______________________________ (name of medical practice or clinic)

______________________ (practice no.) declare that I have taken due care to verify the true identity of

______________________________ (name of applicant).

I have inspected the applicant's:

☐ Identity document ID no. ______________________

☐ Passport Passport no. ______________________

☐ Other means of photographic identification (specify) ______________________

I understand that no payment will be made for the examination unless I sign this declaration.

Signature (medical attendant) ______________________ **Date** D D M M Y Y Y Y

2. Medical history

Have you, or have you ever had any of the following? If YES, give full details in the schedule below.

2.1	High blood pressure	YES ☐	NO ☐
2.2	Rheumatic fever	YES ☐	NO ☐
2.3	Palpitations, irregularity of heart beat, faintness or shortness of breath	YES ☐	NO ☐
2.4	Heart murmur or other affection of the heart or circulatory system	YES ☐	NO ☐
2.5	Cramps in the calves on exercise/walking or any other symptoms of reduced blood supply to the legs	YES ☐	NO ☐
2.6	Pain in the chest, actual or suspected angina pectoris, coronary spasm or coronary thrombosis	YES ☐	NO ☐

2.7 Have you ever had an electrocardiograph or echocardiogram done? If YES, please state:

a. For what reason ______________________

b. By whom ______________________

c. When ______________________

d. Result ______________________

Initials (life insured) ☐

Hollard.

Date	Reason for consultation	Diagnosis	Treatment	Outcome

3. Declaration by life insured

I declare that the statements above are true and complete and shall form part of my application for insurance and I declare that the statements together with my application shall be the basis of the contract between me and Hollard Life.

I authorise Hollard Life to approach any doctor or medical institution to confirm the details of my medical history.

Please take note of the following Hollard disclosures

Protection of Personal Information Act (POPIA)

Hollard cares about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this form. We will treat this information with caution and we have put reasonable security measures in place to protect it.

Financial Intelligence Centre Amendment Act (FICAA)

In accordance with applicable anti-money laundering laws in South Africa, we are required to obtain specific information and evidence to verify your identity (and in many cases the identities of related persons, such as, but not limited to, directors, beneficial owners and persons instructing us on your behalf (where applicable)) when applying for cover and on an on-going basis. If we ask you for information or documents (including originals or certified copies) you must provide them to us as soon as possible. If we do not receive adequate information and evidence within a reasonable time of our request we may be unable to provide you with cover or may cancel the policy in accordance with applicable law.

Signature (life insured) ______________________ **Date** | D | D | M | M | Y | Y | Y | Y |

4. Medical Examiner's Confidential Report

4.1 Height (without shoes) ______ Mass (in clothes) ______ Waist circumference ______

4.2 Blood pressure (to be taken in recumbent posture)

Systolic mm/hg ______ Diastolic mm/hg ______

If BP is over 140/90, record a second reading at the end of the examination.

Systolic mm/hg ______ Diastolic mm/hg ______

4.3 Pulse rate (resting) ______ Is the pulse rate regular? YES ☐ NO ☐

4.4 Is there any evidence of peripheral vascular disease? YES ☐ NO ☐

4.5 Is a murmur present? YES ☐ NO ☐

If yes, describe fully whether systolic or diastolic, note its grade, its position and the direction of propagation. Auscultate with applicant both recumbent and upright and with sustained inspiration and expiration before and after effort.

______

______

______

______

4.6 Are there symptoms of any other cardiovascular abnormality, e.g. cardiac enlargement, cardiac failure, abnormal heart sounds or arrhythmia? YES ☐ NO ☐

If YES, state full details

______

______

______

______

4.7 Is the following present in the urine test?

Protein	YES ☐	NO ☐	If YES, state quantity	______
Glucose	YES ☐	NO ☐	If YES, state quantity	______
Blood	YES ☐	NO ☐	If YES, state quantity	______

4.8 Summary of opinion ______

______

Notice to medical attendants

Hollard Life will reimburse all medical accounts issued according to the insurance billing code A2401 (Specialist physician).

Full name ______

Qualifications ______ Practice no. ______

Work tel. no. ______ Cell no. ______

Email address ______

Postal address ______

Please send your account to ds_doctoraccount@hollard.co.za.

Initials (life insured) ☐

Hollard.

Declaration by medical attendant

I declare that the statements above are true and complete.

Signature (medical attendant) ______________________ **Date** | D | D | M | M | Y | Y | Y | Y |

Hollard declaration

We respect and adhere to patient confidentiality and data privacy principals in relation to Personal Information. We will therefore only process this information for the purpose for which it is intended.