DISEASE MANAGEMENT

PRIVATE AND CONFIDENTIAL BY HAND

Dear Dr _____

Your patient has applied to Hollard Life for life insurance and is most anxious that his/her application is accepted as soon as possible.

Please return this completed form with any relevant copies to ds_uwrequirements@hollard.co.za.

1. Policy details

Policy no. _____ Identity no. _____

Name of insured _____

In order to assess our client's state of health we require your assistance by the completion of the attached form.

We would appreciate special reference to:

HIV history – details of all recent check-ups

1.1 We require details regarding status, date of seroconversion, clinical presentation, treatment, specialist referrals and suggested protocols.

1.2 We require sight of all CD4 and Viral load tests on file. Should a CD4 and Viral load test not have been performed in the last 120 days, your patient will need to supply an up to date viral load test at his/her own expense.

By agreement with the Medical Association of South Africa a statement is incorporated in Hollard Life's application and medical report forms which has been signed by the life to be insured. In this agreement we are authorised to seek and obtain medical information from any Doctor who has attended to him/her.

Regards,

Hollard Life underwriting department

2. Applicant's details

2.1 Give full details of medical examination at date of first consultation for HIV – enclose all blood tests done at initial examination.

_____

_____

_____

_____

2.2 Apart from HIV history, give a summary of any significant symptoms, illnesses (specifically if the patient is on treatment for hypertension, diabetes mellitus, ischemic heart disease, etc). Indicate treatment and efficacy of control.

_____

_____

_____

_____

2.3 Investigations

a. Give latest results and dates of routine blood pressure and urine examinations

_____

_____

_____

_____

b. Enclose any special investigations e.g. ECG's, x-rays, blood tests etc. done during the past 5 years.

Initials

Hollard.

2.4 a. Has your patient consulted any other doctor, hospital or clinic? YES ☐ NO ☐

If YES, give details _____

b. Has your patient ever been treated for:

Any sexually transmitted disease? YES ☐ NO ☐

Depression? YES ☐ NO ☐

Alcohol or Drug abuse? YES ☐ NO ☐

Tuberculosis? YES ☐ NO ☐

c. Do you know of anything that may influence your patient's health, life expectancy or ability to perform his/her own or other occupation? YES ☐ NO ☐

If YES, give details _____

3. Applicant's Health statement (To be completed by medical attendant/health practitioner that is monitoring the client)

3.1 How long have you been the applicant's medical attendant/practitioner? _____

3.2 Is application being managed by:

a. Medical Aid? YES ☐ NO ☐

If YES, supply details of medical aid and number _____

b. Government Clinic? YES ☐ NO ☐

If YES, supply details of file number _____

c. Private Doctor? YES ☐ NO ☐

If YES, supply details of doctor and contact details _____

3.3 Date of first positive HIV test D D M M Y Y Y Y

3.4 CD4 count at date of diagnosis _____ D D M M Y Y Y Y

3.5 Viral Load at date of diagnosis _____ D D M M Y Y Y Y

3.6 Is client on Anti-Retroviral Therapy? YES ☐ NO ☐

3.7 Date that Anti-Retroviral Therapy was started D D M M Y Y Y Y

3.8 CD4 count at date that Anti-Retroviral Therapy was started _____ D D M M Y Y Y Y

3.9 Viral Load at date that Anti-Retroviral Therapy was started _____ D D M M Y Y Y Y

3.10 CD4 count 1 year after Anti-Retroviral Therapy was started _____ D D M M Y Y Y Y

3.11 Viral Load 1 year after Anti-Retroviral Therapy was started _____ D D M M Y Y Y Y

3.12 Result of latest CD 4 count _____ Date D D M M Y Y Y Y

3.13 Result of latest Viral Load _____ Date D D M M Y Y Y Y

3.14 Result of lowest CD 4 count Date D D M M Y Y Y Y

Initials ☐

3.15 Give full details of Anti-Retroviral Therapy that patient is currently on

3.16 Supply details of any previous Anti-Retroviral Therapy as well as the dates of treatment

3.17 Give full details as to how client is responding to treatment/protocol

3.18 How many times per annum does the patient have medical check-ups?

3.19 Please advise date of last checkup

D	D	M	M	Y	Y	Y	Y

3.20 In your opinion, is the patient compliant and following the recommended treatment/protocol?

3.21 Supply copies of all CD4 blood tests or PCR Viral load tests that you have in your possession for this patient.

3.22 In your opinion, if not on any treatment at present, when will your patient require retroviral treatment?

3.23 Do you have any additional information on record that materially affects the life expectancy of the patient?

4. Notice to medical attendants

Hollard Life will reimburse all medical accounts issued according to the insurance billing code A1401 or A4103.

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

5. Declaration by medical attendant

I declare that I have personally attended to the patient and that this form has been completed to the best of my knowledge.

Signature _____ **Date**

D	D	M	M	Y	Y	Y	Y

Hollard Disclaimer

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