Hollard.

PULMONARY/LUNG FUNCTION TEST

(To be completed by 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 ______________________

Hollard Life requires a lung function test performed on a vitallometer showing at least FEV1, FVC and FEV1/FVC values. We would also prefer to receive the flow-volume loops. No comments or interpretations are required.

a. Please explain the procedure carefully to the client and make sure he/she understands what is expected of him/her.

b. If the results are abnormal, it is important that optimal patient co-operation is achieved by obtaining at least two efforts of which the results differ by less than 5%.

c. For persons suffering from obstructive airways disease, efforts must be repeated after a brochodilator inhaler has been given to the patient to evaluate the reversibility of the airways obstruction.

d. Regular calibration of apparatus should be performed by the operator.

General

Please note that the life insured has authorised us to obtain this information from you (and has requested you to provide us with the relevant information) and to share it with other life offices directly or through ASISA for the purpose of underwriting and/or claims assessment. In terms of the ASISA protocol, the life insured may enquire about the information held by ASISA and the pertinent information will be made available to him/her by his/her nominated medical practitioner.

2. Medical attendant details

Hollard Life will reimburse all medical accounts issued according to the insurance billing code A1306.

Full name ______________________

Qualifications ______________________ Practice no. ______________________

Work tel. no. ______________________ Cell no. ______________________

Email address ______________________

Postal address ______________________

Signature
(medical attendant) ______________________

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

3. Declaration by medical attendant

I declare that I have taken due and proper care to verify the true identity of the applicant and have witnessed his/her signature, and have inspected the following:

Identity no. ______________________ or Passport no. ______________________

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

Full name ______________________

Signature ______________________ **Date** | D | D | M | M | Y | Y | Y | Y |

Hollard Declaration

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.