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Confidential Extract from Records Form (PMA)

PLEASE RETURN THIS REPORT TO:

Liberty Life Assurance Uganda Claims Department

For attention T H E M A N A G E R

A claim has been lodged under a policy and to assist us to assess this claim, we need your valued opinion and report urgently.

REQUEST FOR DETAILS EXTRACT FROM CLINICAL RECORDS

Patient's Name

Policy number

Date of birth D D - M M - Y Y Y Y

Address

Postal code

PLEASE SUPPLY THE FOLLOWING DETAILS TO EXPEDITE PAYMENT

Doctor's name

Your practise number

Your bank

Branch code

Account number

Doctor's signature

THIS FORM IS STANDARDISED FOR DEATH, DISABILITY AND DREAD DISEASE. PLEASE THEREFORE ONLY COMPLETE THE APPLICABLE QUESTIONS.

For the purpose confidentiality as indicated above

CONFIDENTIALITY NOTICE

This information is intended for the addressee only and may contain confidential and privileged information. If you are not the addressee, the employee or agent thereof you must not take any action based on the information enclosed. If this facsimile is received in error please notify the sender immediately to arrange return at our expense.

Note: Please ensure that this report is submitted to the Claims Department only and not to any other party.

Scheme name

Name of patient

Name of doctor

NOTE: Please give the patient's medical history from the first date of consultation with yourself or your practice

First consultation D D - M M - Y Y Y Y

Last consultation D D - M M - Y Y Y Y

CONSULTATION DATES	REASONS FOR CONSULTATIONS, DIAGNOSIS, TREATMENT AND RESULTS	DURATION

PLEASE PROVIDE DETAILED COMMENTS ON THE FOLLOWING:

1. In your opinion, did any previous illness, family history or habits in any way contribute to the reason for claim? ☐ Yes ☐ No

If "yes", what was the reason.

2. Is there any reason to believe that your patient's illness, disorder or inability to follow a remunerative occupation is an any way due to or arises directly or indirectly, entirely or partially from AIDS or HIV Infection? ☐ Yes ☐ No

If "yes", what was the reason.

Has your patient ever been tested for HIV antibodies? ☐ Yes ☐ No

If "yes", what was the result of the test?

3. Are you aware of any factors relevant to your patient's family history, present health, medical history or habits which in your opinion may affect our assessment?

4. Date of death D D - M M - Y Y Y Y

5. Was the death due to trauma, suicide or other unnatural causes? ☐ Yes ☐ No

Cause of death

Was a postmortem examination performed? ☐ Yes ☐ No

Was an inquest held? ☐ Yes ☐ No

If "Yes" please provide full details i.e. Where, Date, Inquest No., etc

6. What was the immediate cause of death?

What was the primary cause of death and its date of onset?

Did the deaceased suffer from any other associated diseases or conditions? Please give particulars including dates of consultation etc

Your assistance is greatly appreciated and your report will be treated in the strictest of confidence.

I the undersigned, _____ a duly registered medical practitioner, hereby certify that the information is an accurate reflection of the deceased medical history and is true, correct and complete.

Signed at , _____ this , _____ day of , _____ 20, _____

Doctor's full name

Telephone number Fax

Physical address

Code

E-mail address

First consultation D D - M M - Y Y Y Y

Doctor's signature Date D D - M M - Y Y Y Y

DOCTOR'S STAMP