Procedure for claiming sickness benefits

The payment of sickness benefits is subject to certain claim procedures and in order to settle claims promptly, members are requested to follow the correct procedure.

Claims for sickness benefits must be made on the appropriate claim form, and must be accompanied by a PPS Insurance medical certificate from the attending doctor or dentist.

Please ensure that all details are filled in correctly as incorrect information or failure to answer any of the questions will result in a delay in the processing of your claim.

A claim for sickness benefits consists of two parts, namely a declaration by the medical doctor/dentist and a declaration by the member.

A. Declaration by medical doctor/dentist

1. The medical practitioner/dentist must complete this form.
2. Point 2: Inception date and end date should be in accordance with the period of illness.
3. Total/partial sickness benefits: Total is when the member is totally unable to attend his/her usual professional duties. The member is entitled to claim partial sickness benefits after a minimum period of seven consecutive days total sickness.
4. The doctor should preferably sign the form on or after the end date mentioned in point 2.

B. Declaration by member

1. The member must complete this form.
2. Point 4: Inception date and end date should be in accordance with the period of illness.
3. The member should preferably sign the form on or after the end date mentioned in point 4.
4. If an accident is the cause of a member not being able to perform his/her usual professional duties, the member should provide us with details on how the accident occurred in point 6.

C. General

1. The member must be totally unable to attend to his/her normal professional duties for a minimum period of seven days before he/she is entitled to claim.
2. The doctor (*not the member*) must complete medical certificates.
3. Ongoing claims must be submitted on a monthly basis, unless otherwise indicated by the PPS medical officer.
4. When submitting ongoing claims, each monthly claim should be dated from the first date to the last date of the month being claimed, e.g. 1.1.2007 – 31.1.2007 and the following month 1.2.2007 – 28.7.2007 and so on.
5. Hospital benefits, where applicable, can only be paid on receipt of hospital account and if the member is hospitalised for a minimum of **four** consecutive days.
6. Post-dated claim forms are not accepted.
7. Claims submitted after six months from date of onset of illness will not be considered.
8. Please allow five working days before querying the progress of your claim.
9. Complete claim forms in full – failure to answer any of the questions will result in a delay in the processing of your claim.
10. In some instances it will be necessary to obtain further information before a claim can be assessed.

PPS INSURANCE COMPANY LIMITED
CLAIM FOR SICKNESS BENEFIT
PAYMENT DETAIL FORM

6 Anerley Road
Parktown

PO Box 1089
Houghton, 2041

Tel : 011 644 4200
Fax: 011 644 4520

Policy Number:	Surname:	Initials:
ID Number:	**Postal Address:**	
Tel No: H ( )	**Tel No: W ( )**	
Fax No: ( )	**Cell No:**	**Email Address:**

1	**Banking details for SICKNESS BENEFIT via *Electronic payment*:** **(please attach a cancelled cheque – if applicable)** Name of Bank: …………………………………………………………………………………………….. Branch Code: ………………………………………………………………………………………………. Account Holder: ……………………………………………………………………………..….…..……. Account Number: ……………………………………………………………………………………….…. Type of Account: …………………………………………………………………………………………..

<u>Indemnity:</u> Please take note that PPS will not be held liable for incorrect payments, if the information received is incorrect.

I certify that all the above information is correct.

SIGNED AT (Place): ___________________

DATE: _______________ SIGNATURE:______________________

Professional Provident Society Insurance Company Limited

Reg. No. 2001/017730/06 ("PPS Insurance")

6 Anerley Road, Parktown
Johannesburg, 2193
P.O. Box 1089, Houghton, 2041
Head Office Tel: (011) 644-4200
Fax: 0800 203 194
E-mail: info@pps.co.za
Website: www.pps.co.za

CLAIM FOR SICKNESS BENEFIT
(Declaration by Doctor/Dentist)

Policyholder no ____________

Instructions: To be completed by the attending doctor/dentist ONLY.
Please answer all questions in black ink and tick [✓] the appropriate block.

Surname: ____________ Initials: ____________ Date of Birth: ____________

1.a) The above policyholder first consulted me for this current condition on: dd ______ mm ______ yy ______

and again on the following dates: dd ______ mm ______ yy ______

dd ______ mm ______ yy ______

dd ______ mm ______ yy ______

____

Primary diagnosis: ____________

Secondary condition (if present): ____________

b) Was the incapacity due to an illness? Yes ☐ No ☐

If yes, please provide details: ____________

c) Was the incapacity due to an injury? Yes ☐ No ☐

If yes, Cause of injury: ____________

Date of injury: ____________

Details of injury: ____________

2. As a result of the above incapacity, the policyholder was **TOTALLY** unable to fulfill their professional duties for the period:

From: dd ______ mm ______ yy ______ **To:** dd ______ mm ______ yy ______ *AND/OR*

As a result of the above incapacity, the policyholder was able to resume their professional duties on a **PART-TIME** basis:

From: dd ______ mm ______ yy ______ **To:** dd ______ mm ______ yy ______

3. Was the policyholder hospitalised for the above condition? Yes ☐ No ☐

Admission date: ____________

Discharge date: ____________

4. Was any surgery performed? Yes ☐ No ☐

If yes, specify type of operation / procedure: ____________

5. Were there any complications, which prolonged the incapacity beyond what can be reasonably expected for a condition of this nature?

____

____

6. a) Is there any reason to believe that the policyholder's death, illness, disorder, incapacity, disability or inability to follow a remunerative occupation is in any way due to or arises directly or indirectly, entirely or partially from AIDS or HIV infection? Yes ☐ No ☐

If yes, please provide full details: ____________

____

b) Has the policyholder ever been tested for HIV antibodies? Yes ☐ No ☐

If yes, what was the result of the test: ____________

Name: ____________ Qualification: ____________

HPCSA Reg. No.: ____________ Practice No.: ____________

Postal Address: ____________ E-mail address: ____________

____________ Telephone No: ____________

____________ Fax No: ____________

Signed at: ____________ this ____________ day of ____________ 200______

Signature: ____________

The cost of the completion of the medical certificate is the responsibility of the patient.
This form is confidential and should not be given to the patient (policyholder),
but please post or fax to PPS Insurance - 0800 203 194

Professional Provident Society Insurance Company Limited

Reg. No. 2001/017730/06 ("PPS Insurance")

6 Anerley Road, Parktown
Johannesburg, 2193
P.O. Box 1089, Houghton, 2041
Head Office Tel: (011) 644-4200
Fax: 0800 203 194
E-mail: info@pps.co.za
Website: www.pps.co.za

CLAIM FOR SICKNESS BENEFIT
(Declaration by Policyholder)

Policyholder no [ ]

Instructions: All answers are strictly confidential and for the information of our Medical Advisor/s.
Please refer to Appendix A2(1) (a)(i) of the PPS Master Contract concerning late submissions.
Please answer all questions in black ink and [✓] the appropriate block.

Surname: ______ Initials: ______ Date of Birth: ______

Tel. no. (h): ______ Tel. no. (w): ______

Cell no.: ______ Fax no.: ______

Postal Address: ______

E-mail: ______

1. Please state the profession which you were practising immediately prior to the period for which you are claiming:

______

2. (a) Are you employed? Full Time? [ ] Part Time? [ ]
   (b) Are you in private practice? Full Time? [ ] Part Time? [ ]
   (c) Are you unemployed? Yes [ ] No [ ]
   If so, from which date: dd______ mm______ yy______

3. I, the above named, declare that I was incapacitated during the period:
   From: dd______ mm______ yy______ **To:** dd______ mm______ yy______
   (a) I did not carry out **any** duties, which utilised my professional knowledge, experience and training:
   From: dd______ mm______ yy______ **To:** dd______ mm______ yy______ *AND/OR*
   (b) I carried out my duties **on a limited scale** (partial incapacity):
   From: dd______ mm______ yy______ **To:** dd______ mm______ yy______
   and, was able to perform the following duties: ______
   (c) I resumed my usual professional duties on: dd______ mm______ yy______

4. Is the claim due to an illness? Yes [ ] No [ ]
   If yes, specify the nature of the illness: ______

5. Is the claim due to an injury? Yes [ ] No [ ]
   If yes: Date of injury: ______
   Cause of injury: ______
   Nature of injury: ______

6. Were you hospitalised? Yes [ ] No [ ]
   If yes: Name of hospital: ______
   Admission date: ______
   Discharge date: ______
   N.B.If hospitalised for 4 days or more and you have PPS hospital benefits, please attach PROOF of your hospital admission and discharge.

7. Please state the name(s) of the doctor(s) and / or dentist(s) that attended to you, in respect of this claim / current incapacity, as well as their phone and fax number(s). Indicate clearly with a [✓], which practitioner declared you incapacitated, and can be contacted for further information if required.

✓	Practitioner's surname & initials	Consultation date	Phone number	Fax number	May be contacted
[ ]	(a) ______	______	______	______	**Yes / No**
[ ]	(b) ______	______	______	______	**Yes / No**
[ ]	(c) ______	______	______	______	**Yes / No**

8. **Female policyholders only:** Are you pregnant? Yes [ ] No [ ]
   If yes, estimated date of delivery: ______
   Please refer to Appendix A10 of the PPS Master Contract concerning pregnancy related claims.

9. Please supply any other relevant history and details regarding the claim: ______

______

I certify that all the above information is correct.

Signed at: ______ this ______ day of ______ 200 ______

Signature: ______