Declaration by attending doctor/dentist for a Sickness benefit claim

Important:

- To be completed by the attending doctor/dentist only. (If abroad, provide all medical documentation in English)
- Any cost involved to complete this form is the responsibility of the claimant.
- An accurately completed form is essential in order to avoid delays in the assessment process. Please complete all questions.
- Legible copies of original documents may be submitted instead of the originals.

Please supply the following additional completed document:

- Legible copies of certificates of illness provided by attending doctor or dentist. (If available.)

Contact details:

Telephone number: (021) 916-3455
Fax number: (021) 957-2288
e-mail address: sickness@sanlam.co.za

For Namibian policies refer to: claims.affluentsupport@sanlam.com.na or contact our Sanlam Namibia office at +264 61 294 7440.

Plan number(s) 044798449X3

Particulars of claimant

Surname Potgieter

Full first names Dewald Mathys

Date of birth 08/05/1990 (dd/mm/ccyy)

Nature of claim and particulars of consultations

State the initials, surname and contact details of the doctor who referred the patient to you:

Tutyeni-Oletu Nghaamwa

Telephone number (086) 374 7687 Fax number ( )

The claimant first consulted me for this current condition on 27/05/2025 (dd/mm/ccyy)

Follow-up consultation dates 4 June 2025 (dd/mm/ccyy)
1 July 2025 (dd/mm/ccyy)
(dd/mm/ccyy)
(dd/mm/ccyy)

Primary diagnosis

Diagnostic code (ICD -10) for primary diagnosis

Secondary diagnosis

Diagnostic code for secondary diagnosis (ICD -10)

As a result of the above diagnosis the claimant was **totally** unable to fulfil his/her professional duties for the period:

From 24 May 2025 (dd/mm/ccyy) To: 9 June 2025 (dd/mm/ccyy)

Was the sick leave due to: Illness [ ] Injury [X] (Please mark the applicable option with an X.)

Describe the nature/details of the illness or injury

Date when the illness first started/injury occurred 24 May 2025 (dd/mm/ccyy)

Was the claimant hospitalised? Yes [ ] No [X]

If "Yes": Admission date: (dd/mm/ccyy) Discharge date: (dd/mm/ccyy)

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Nature of claim and particulars of consultations (continued)

Was any surgery performed? Yes ☐ No ☒

If "Yes", please specify the type of operation/procedure.

Date of operation _____ (dd/mm/ccyy)

Operation code (CPT4) _____

NB - Prolonged/extended sick leave period

Were there any complications/comorbidities, which prolonged the sick leave beyond what can be reasonably expected for a condition of this nature? (Please include copies of specialist reports.)

Yes ☐ No ☐

If "Yes", please comment on these complications/comorbidities as well as the reason for the extended sick leave.

Is the insured currently at work? Yes ☒ No ☐

Particulars of doctor/dentist

Full names and surname _____

Medical Board Registration Number _____

Qualification _____

Practice number _____

Telephone number (041) 363 3958 Fax number ( )

Postal address _____

e-mail address ashwink@netactive.co.za

Signature of doctor/dentist _____

Date 14/07/2025 (dd/mm/ccyy) Place Port Elizabeth