TRANSPORT SECTOR RETIREMENT FUND

TRANSPORT
Sector Retirement Fund
Moving Towards A Better Future

DISABILITY CLAIM

salt
EMPLOYEE BENEFITS

CONFIDENTIAL MEDICAL REPORT BY ATTENDING PHYSICIAN
To be completed by the attending physician

Dear Member
Please request your attending physician to complete this Confidential Medical Report as required by the Transport Sector Retirement Fund ("Fund"). You will be responsible for paying the physician for completing the medical report(s). In an instance where a specialist is not consulted, a report from the attending physician or general practitioner will be accepted but may result in further medical evidence being requested.

Dear Doctor
The Fund has received an application for a disability claim for this member and would appreciate you completing this Confidential Medical Report. It is essential that you complete this form as fully as possible to prevent any unnecessary delays. The cost of completing this Confidential Medical Report will be paid by the member.
If you have any reports of previous investigations to substantiate the diagnosis, please include copies.
The request for completion of this form in no way constitutes an admission of liability by the Fund.
If the member is only consulting a physician or general practitioner, the Fund suggests he / she consults a specialist at his / her nearest provincial hospital for completion of the forms and reports.
Purpose of this form: To assess the member's impairment (medical assessment), and to ascertain;
- Change in functional capacity due to illness or injury
- Diagnosis
- Optimal medical treatment

A. MEMBER DETAILS

Surname of Member			
First Names of Member			
Date of Birth	D D M M Y Y Y Y	ID/Passport No	
Gender (Female/Male)		Employee Number	
Current Employer			

D. IMPAIRMENT DETAILS AND HISTORY

Member's height in cm		Member's weight in kg	
Date of first consultation	D D M M Y Y Y Y	Date of last consultation	D D M M Y Y Y Y
On what date did the first symptoms of the condition claimed for, appear?		D D M M Y Y Y Y	
If you are still attending to the member, when was the last consultation?		D D M M Y Y Y Y	
When was the member's last day at work / date of disability?		D D M M Y Y Y Y	

Please complete the information below:

Date	Reason for consultation	Diagnosis	Treatment	Result / Prognosis

Have clinical investigations been performed to determine the condition?	Yes		No	

If yes, comment on the results of all tests / examinations performed to confirm diagnosis (please include copies)

How has the member's condition been treated over the past 12 months? (Discuss treatment regimen prescribed)

Date	Treatment (medication and dosage)	Outcome

Is future surgery / treatment planned? (if applicable)	Yes		No	

If yes, what type of surgery / treatment and when?

Notwithstanding the treatment regimen described above, and the envisaged cost thereof, what further treatment would you recommend to improve the member's condition and / or activities of daily living?

Please provide a full description of any related conditions that the member has

Please provide a full description of any related symptoms that the member has

Do you know of any other factors (e.g. previous illness or injury, hazardous pastimes or pursuits, habits or self inflicted injuries) that may have contributed in any way to the member's impairment?

If 'Yes', please comment fully

In your opinion, when will the member be able to go back to work?

Part-time	Date	D	D	M	M	Y	Y	Y	Y	Duties	
Full-time	Date	D	D	M	M	Y	Y	Y	Y	Duties	

If the member has already recovered and returned to work, please give the date of his / her return to work D D M M Y Y Y Y

Please provide any additional information which you feel will assist the Fund in the assessment of this claim (if there is not enough space provided on this form, please continue on a separate sheet)

Have you included copies of all tests and reports?	Yes		No

Additional comments

E. DETAILS OF ATTENDING PHYSICIAN

Attending Physician's Name				
Attending Physician's Surname				
Attending Physician's Physical Address				
		Country		Code
Attending Physician's Postal Address				
		Country		Code
Attending Physician's Cell Phone Number		Attending Physician's Tel. No		
Attending Physician's Email Address		Attending Physician's Fax No		
Attending Physician's Qualifications				

F. ATTENDING PHYSICIAN'S DECLARATION

I, _____(full name) the attending medical practitioner hereby confirm and declare that: All information provided in this Confidential Medical Report, whether in my handwriting or not, is true and correct. This Confidential Medical Report was completed by me, duly authorised. I understand the information provided and confirm that same is true and correct. I have not withheld any information that will have relevance to the acceptance / declining of this claim. Should any information be found to be fraudulent, the Fund and / or the Fund Service Providers reserve the right to proceed with the appropriate action against me as the liability to provide accurate and complete information, rests with me. In the event of any loss suffered as a result of any details provided in this Confidential Medical Report being inaccurate, incorrect, incomplete or fraudulent, neither the Fund nor the Fund Service Providers will be liable for such loss.

Signature of Attending Physician: _____ Date Signed: _____

Notes:

In some instances, further documents and /or information may be required to determine the validity of a claim. All documents required in the claim notification must be submitted and failure to do so timeously, may result in claim payments being delayed and / or Disability risk benefit claims being declined. Disability Claims are assessed on receipt of complete documentation, including the fully completed Confidential Medical Report, and failure to do so, will result in the delay of processing the claim.

I. SUBMISSION DETAILS

Claim Type	Electronic	Fax	Telephone Enquiries	Physical address
Disability	members@rflipf-sanlam.co.za	011 544 8302	011 544 8300	SALT Employee Benefits (Pty) Ltd, Central Park Office No 400, 16th Road Randjespark Office Block Q, Midrand