



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 <i>Electronic payment</i>. (please attach a cancelled cheque – if applicable) Name of Bank: Branch Code: Account Holder: Account Number: Type of Account:	

Indemnity: 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")

CLAIM FOR SICKNESS BENEFIT (Declaration by Doctor/Dentist)

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

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.

<input checked="" type="checkbox"/>	Practitioner's surname & initials	Consultation date	Phone number	Fax number	May be contacted
<input type="checkbox"/>	(a) _____	_____	_____	_____	Yes / No
<input type="checkbox"/>	(b) _____	_____	_____	_____	Yes / No
<input type="checkbox"/>	(c) _____	_____	_____	_____	Yes / No

8. **Female policyholders only:** Are you pregnant? Yes No

If yes, estimated date of delivery: _____

Please refer to Appendix A 10 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: _____