Hill on Empire Office Park
2nd Floor Building B
Cnr Empire Rd and Hillside Road
Parktown
2193

Postnet Suite 409, Private Bag X30500, Houghton, 2041

T 0860 64 54 33
E info@life.miway.co.za

Personal Medical Report

The medical information in this form is in support of a claim. Your expertise and advice will provide a vital link in the process of assessing the claims. This form needs to be completed by the attending doctor.

Please supply MiWayLife with copies of all available tests, histology, pathology, x-rays, scans, and any other test reports that you might have.

Section A: Particulars of the Insured (Claimant)

a. Policy Number: _____

b. Full first name(s) and Surname: _____

c. ID Number: _____

d. Date of Birth: _____

Section B: History of Consultations / Hospitalisation / Investigations

How long have you been the insured's usual medical attendant? _____

Please give a summary of any significant symptoms, or illnesses (specifically if the patient is on treatment for hypertension, diabetes mellitus, stroke, ischemic heart disease, etc.). Please indicate the treatment and efficacy of the control. _____

_____

_____

_____

_____

_____

Please complete the following, include as much detail as possible for ALL consultations, and attach all relevant reports such as ECG, Blood laboratory reports, scans, or any other special investigations done.

Date of Consultation	Reason for Consultation	Diagnosis	Treatment	Any test results e.g., Cholesterol or Glucose test

Did the patient use any Chronic Medication for longer than one month? Please confirm the medication prescribed and the period the patient has been taking the medication.

Did the patient have any special examination? For example, ECGs, X-rays, or Tests? Please provide details.

Date	Special Examination	Result

Have any additional or special examinations been carried out for any other conditions not mentioned above? Please provide full details

Has the patient ever been tested for HIV or any sexually transmitted disease? Please provide the date of the test and the result

Date	Test	Result	Treatment

Did the patient smoke cigarettes, pipe tobacco, or use any other tobacco products? Please provide details and duration.

Did the patient use un-prescribed drugs, e.g., Tik, Dagga, Mandrax, Cocaine? If yes, supply full details and duration of use.

Please provide the following information, including the date:

Date of the reading	Height in cms	Weight in Kg

Section C: Other Doctors / Hospitals

Has your patient consulted any other doctor, hospital, or clinic? If yes, please provide details.

Doctor 1

Dr. _____ Address: _____

Telephone number: _____ Cellphone number: _____

E-mail address: _____

Consultation date(s): _____

A short description of the reason for consultation: _____

_____

Doctor 2

Dr. _____ Address: _____

Telephone number: _____ Cellphone number: _____

E-mail address: _____

Consultation date(s): _____

A short description of the reason for consultation: _____

_____

Doctor 3

Dr. _____ Address: _____

Telephone number: _____ Cellphone number: _____

E-mail address: _____

Consultation date(s): _____

A short description of the reason for consultation: _____

_____

Hospital / Clinic

Name of the Hospital / Clinic: _____

Address: _____

Attending doctor: _____ Contact detail: _____

Consultation date(s): _____

A short description of the reason for consultation: _____

_____

_____

Hospital / Clinic

Name of the Hospital / Clinic: _____

Address: _____

Attending doctor: _____ Contact detail: _____

Consultation date(s): _____

A short description of the reason for consultation: _____

_____

_____

Sector D: Doctor's Details and Declaration

a. Initials and surname: _____

b. Qualifications: _____ Practice number: _____

c. Physical address: _____

_____ Code: _____

d. Telephone number: _____ Email address: _____

Declaration

I declare that to the best of my knowledge, all information that I have given in this form is accurate and that I have not withheld any information which could influence the decision on this claim. I further declare that I understand that my failure to disclose relevant information in respect of this claim may invalidate the claim. I acknowledge that I fully understand the contents of this declaration.

Signed at _____ on this _____ day of _____20_____.

_____

Signature

MiWayLife Disclosures

POPIA

MiWayLife cares about the privacy of its clients. To provide the insured with our service, we and our service providers must process the personal information you provide us in line with the applicable data privacy laws. As a result, we will treat this information with caution, and we have put reasonable security measures in place to protect it.