Hill on Empire Office Park, 2nd Floor Building B,
Corner Empire Road and Hillside Road, Parktown, 2193

Postnet Suite 409, Private Bag X30500, Houghton, 2041

086 064 5433 | claims@go.miwaylife.co.za

miwaylife

Life Insurance **reimagined**

REQUEST FOR EXTRACT OF MEDICAL HISTORY (MEDICAL SPECIALIST DETAILS)

Terminal Illness: If the main insured is diagnosed with terminal illness and is likely to die within a year, he/she may exercise the option to claim 50% and 100% of the life cover amount. To qualify for payment of the terminal illness benefit, an independent specialist appointed by MiWayLife must confirm the diagnosis.

Please supply MiWayLife with copies of all available tests, histology, pathology, x-rays, scans, and any other test reports that might be available on the patient file.

Section A: Particulars of the Insured (Claimant)

Policy Number _____

Full first name(s) and Surname _____

ID Number _____ **Date of Diagnosis** _____

Section B: History of Consultations

Since when have you been the attending Specialist/Physician/Oncologist?

Date from _____ **Date to** _____

Please provide the full details of any doctor, clinic, or hospital that referred the patient to your practice. Additionally, provide a copy of the referral letter for our perusal.

_____

_____

_____

_____

_____

Please confirm the patient's symptoms during the initial consultation.

_____

_____

_____

_____

Please confirm the initial diagnosis made during the consultation and any further tests that were performed.

_____

_____

_____

_____

_____

What tests were conducted to confirm the diagnosis? Kindly provide copies of all the tests performed.

Can you confirm the type of condition the patient was diagnosed with?

Is there any reason to believe that the diagnosis was caused by, or was a result of, any medical condition, social habit or environmental exposure of the patient, prior to the diagnosis? If so, could you please elaborate?

Please explain the staging of the diagnosis

What special investigations were conducted to determine the staging of the condition?

Please provide us with the TNM staging, if applicable, of the condition as confirmed by testing and staging of the condition?

Can you confirm if this is the patient's first diagnosis, or if there were any previous diagnoses before the recent one?

Has the condition metastasised to any other organs? **YES** ☐ **NO** ☐

Please provide the current treatment plan for the patient.

What is the prognosis for the patient? IMPORTANT: If the prognosis is poor or guarded, could you please confirm whether the life expectancy is less than 12 months and if the prognosis is considered terminal?

Is the patient currently in remission? Please select YES or NO **YES** ☐ **NO** ☐

Did the patient suffer from any other chronic medical conditions that required ongoing treatment during the first consultation? If so, please specify the condition(s) and any chronic medication the patient was using at the time.

Do you have any further information you feel is important to note?

Please complete the following and include as many details as possible for <u>all</u> consultations. Kindly attach all relevant reports, such as ECGs, blood test results, scans, or any other special investigations performed.

Consultation Date	Reason for Consultation	Treatment

Was the patient ever hospitalized or admitted to any institution? YES ☐ NO ☐

Duration of Stay	Reason or presenting symptoms on admission	Hospital or Institution name	Treatment Details	Final Diagnosis

Section C: Other Doctors

Are you aware of any other doctors the patient was referred to, or consulted with? YES ☐ NO ☐
If YES, please provide details

Doctor 1

Dr. _____ **Address** _____

Telephone number _____ **Cell phone number** _____

E-mail address _____ **Consultation date(s)** _____

Please give a short description of the reason for the consultation.

_____

_____

_____

Doctor 2

Dr. _____ **Address** _____

Telephone number _____ **Cell phone number** _____

E-mail address _____ **Consultation date(s)** _____

Please give a short description of the reason for the consultation.

_____

_____

_____

_____

Doctor 3

Dr. _____ **Address** _____

Telephone number _____ **Cell phone number** _____

E-mail address _____ **Consultation date(s)** _____

Please give a short description of the reason for the consultation.

_____

_____

Section D: Doctor's Details and Declaration

Initials and surname _____

Qualifications _____ **Practice number** _____

Physical address _____

_____ **Code** _____

Telephone number _____ **Email address** _____

Declaration

I, the undersigned, a registered Medical Practitioner declare to the best of my knowledge, that all information provided in this document has been competed to the full extent of my knowledge and warrants a true representation of all information in respect of the patient named in this document and that I have not withheld any information which could influence the decision on this claim. I further declare that I understand that 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 _____

Official Stamp

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.

FICA
In line with the applicable anti-money laundering laws of South Africa, we are required to obtain specific information and evidence to verify your identity when applying for cover and on an ongoing basis. If we do not receive the requested information within a reasonable time, we may be unable to render our services.