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miwaylife

Life Insurance **reimagined**

REQUEST FOR EXTRACT OF MEDICAL HISTORY (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 claim. 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)

Policy Number _____

Full first name(s) and Surname _____

ID Number _____ **Date of Diagnosis** _____

Section B: Lifestyle information

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

Did he/she smoke cigarettes, pipe tobacco, or use any other tobacco/nicotine products? **YES** ☐ **NO** ☐

If "YES", please provide details and duration _____

Did he/she use non-prescribed addictive substances e.g. Tik, Dagga, Mandrax, Cocaine? **YES** ☐ **NO** ☐

If "YES", please provide more details (e.g. referral for treatment) _____

Please provide information regarding patient's length and weight

Date of Reading	Height in Centimetres (cm)	Weight in Kilograms (kg)

Section C: Medical information

Did the patient suffer from Diabetes? **YES** ☐ **NO** ☐

If "YES", state date of diagnosis, treatment given and duration? _____

Did the patient suffer from Hypertension? **YES** ☐ **NO** ☐

If "YES", state date of diagnosis, treatment given and duration? _____

Did the patient suffer from Cholesterol? YES ☐ NO ☐

If "YES", state date of diagnosis, treatment given and duration? _____

Has the patient ever been tested for HIV or any sexually transmitted disease? YES ☐ NO ☐

If "YES", please provide the dates and test results below.

Date	Test	Results	Treatment

Did the patient use any Chronic Medication for longer than one month? YES ☐ NO ☐

If YES, please specify the prescribed medication and the duration of use.

Was the patient ever diagnosed/treated for any organ failure (Cardiovascular, Nervous System, Gastrointestinal (GIT), Kidney, Respiratory conditions/diseases)? YES ☐ NO ☐

If "YES", please state date of diagnosis, treatment given and duration? _____

Was the patient ever diagnosed with any psychological conditions? YES ☐ NO ☐

If "YES", please state date of diagnosis, treatment given and duration? _____

Please provide details of ALL consultations, and attach all relevant reports (e.g., ECGs, Blood test results, Scans, or other special investigations that was done).

Date of Consultation	Reason for Consultation	Diagnosis	Treatment and Duration	Any test results

In the last 10 years, was the patient ever hospitalised or admitted to any medical institution for a period longer than 48 hours? YES ☐ NO ☐

If "YES", please provide full details of the institution as well as reason for admission.

Date	Name of Hospital/Institution	Duration

Section C: Other Doctors

Has your patient consulted any other doctor, hospital, or clinic? YES ☐ NO ☐

If "YES", please provide the doctor's 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.