Liberty Life Insurance Zambia Limited
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Confidential Extract from Records Form (PMA)

PLEASE RETURN THIS REPORT TO:

Lifeway Insurance Zambia Limited Claims Department

For attention

Fax number + 2 6 0 2 1 1 2 5 5 5 3 7

Phone number + 2 6 0 2 1 1 2 5 5 5 3 6

The information contained in this document is strictly confidential and intended for sole use by the medical practitioner to whom it is addressed.

REQUEST FOR DETAILS EXTRACT FROM CLINICAL RECORDS

Patient's Name

Scheme name

Date of birth D D - M M - Y Y Y Y

Address

Postal code

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Lifeway will pay for the cost of this report , please include invoice for amount payable.

PLEASE SUPPLY THE FOLLOWING DETAILS TO EXPEDITE PAYMENT

Doctor's name

Your practise number

Your bank

Branch code

Account number

Doctor's signature

THIS FORM IS STANDARDISED FOR DEATH, DISABILITY AND DREAD DISEASE. PLEASE THEREFORE ONLY COMPLETE THE APPLICABLE QUESTIONS.

For the purpose confidentiality as indicated above

CONFIDENTIALITY NOTICE

This information is intended for the addressee only and may contain confidential and privileged information. If you are not the addressee, the employee or agent thereof you must not take any action based on the information enclosed. If this facsimile is received in error please notify the sender immediately to arrange return at our expense.

Note: Please ensure that this report is submitted to the Claims Department only and not to any other party.

NOTE: Please give the patient's medical history from the first date of consultation with yourself or your practice

First consultation D D - M M - Y Y Y Y

Last consultation D D - M M - Y Y Y Y

1.

CONSULTATION DATES	REASONS FOR CONSULTATIONS, DIAGNOSIS, TREATMENT AND RESULTS	DURATION

2. Please provide detailed comments on the following:

3. What is the current prognosis? (Not applicable in the event of death)

4. To the best of your knowledge has any of the above illnesses resulted in your patient being frequently absent from work? ☐ Yes ☐ No

5. (a) If any additional or special examinations have been carried out or you have referred your patient to any other doctor or hospital, please give details. Could we please have sight of ECG'S/ investigation reports etc.

(b) Was your patient referred to or attended by any other Medical Doctor, Physician, Sugeon or any other person associated with any medical history including traditional healers, etc within the past 5 years? ☐ Yes ☐ No

If "Yes", please give full details

(c) Please provide name of doctors/hospital/institution/patient's file number

(d) In your opinion, did any previous illness, family history or habits in any way contribute to the reason for claim? ☐ Yes ☐ No

If "Yes", what was the reason.

6. (a) Ils there any reason to believe that your patient's illness, disorder or inability to follow a remunerative occupation is an 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 your patient ever been tested for HIV antibodies? ☐ Yes ☐ No

If "Yes", what was the result

7. Are you aware of any factors relevant to your patient's family history, present health, medical history or habits which in your opinion may affect our assessment?

8. Please advise if Life Assured

(a) Consumed liquor? ☐ Yes ☐ No

(b) Did he/she ever receive medical attention or advice to reduce liquor, substance abuse or tobacco or was there a history of change inconsumption or use? ☐ Yes ☐ No

If "Yes", please provide full details.

(c) History of other substance abuse ☐ Yes ☐ No

9. Please advise if the patient used tobacco in any form e-cigarettes, hubbly bubbly (including snuff) in the past 12 months? ☐ Yes ☐ No

If "Yes", please provide full details i.e. amount: etc

Your assistance is greatly appreciated and your report will be treated in the strictest of confidence.

IN ADDITION, THIS SECTION MUST BE COMPLETED IF YOUR PATIENT IS DECEASED

1. Please state:

Date of death D D - M M - Y Y Y Y Age at death

Place of death (if an institution or hospital, please state name etc.

If hospital, please provide admission/patient number and names of treating doctors.

2. Was the death due to trauma, suicide or other unnatural causes? ☐ Yes ☐ No

Cause of death

Was a postmortem examination performed? ☐ Yes ☐ No

Was an inquest held? ☐ Yes ☐ No

If "Yes" please provide full details i.e. Where, Date, Inquest No., etc

3. What was the immediate cause of death?

Were you the person who notified the death? ☐ Yes ☐ No

If "No" please advise, who provided the notification

Your assistance is greatly appreciated and your report will be treated in the strictest of confidence.

I the undersigned, _____ a duly registered medical practitioner, hereby certify that the information is an accurate reflection of the deceased medical history and is true, correct and complete.

Signed at , _____ this , _____ day of , _____ 20, _____

Doctor's full name

Telephone number Fax

Physical address

Code

E-mail address

First consultation D D - M M - Y Y Y Y

Doctor's signature Date D D - M M - Y Y Y Y

DOCTOR'S STAMP