employeebenefits@triarc.co.za • www.triarc.co.za
Phone: 087 231 0222 • Fax: 086 235 5238
PO Box 569, Milnerton, Cape Town, 7441

Unit 329 Mayfair, Century Avenue
Century City, 7441

Group Risk Disability Benefit Claim Form - Medical Progress report

How to complete this form

Dear health professional

Please answer each question in full. Do not use a dash, correction fluid or leave blank. Include copies of test results and reports for example pre- and post-operation reports, histology reports, blood test results, x-ray reports, ECG and scans to support the diagnosis. The claimant is responsible for the cost of the initial medical report.

1. Health Professional Details

Surname

First Names

Qualifications / Speciality

Other Qualifications

Practice Number

HPCSA Registration Number

E-mail Address

Practice Address

Code

Telephone Number

Fax Number

E-mail Address

2. Scheme Details

Scheme Name

Policy Number

Postal Address

Code

Contact Person

Date of Birth Y Y Y Y M M D D

ID Number

Country of Origin

Designation

Telephone Number

E-mail Address

3. Details of Claimant

Surname

First Names

Initials

Date of Birth Y Y Y Y M M D D

ID Number

Country of Origin

Telephone Number

Cellphone Number

4. Member's Medical Condition

The period the member was a patient of the practice/clinic/hospital or institution

From Y Y Y Y M M D D to Y Y Y Y M M D D

Date of first examination Y Y Y Y M M D D

What was the diagnosis?

Please give the details of why the member consulted the practice:

1

Date of Consultation Y Y Y Y M M D D

Presenting symptoms and/or complaints

Diagnosis (include blood pressure readings and tests results)

Treatment

2

Date of Consultation Y Y Y Y M M D D

Presenting symptoms and/or complaints

Diagnosis (include blood pressure readings and tests results)

Treatment

3

Date of Consultation Y Y Y Y M M D D

Presenting symptoms and/or complaints

Diagnosis (include blood pressure readings and tests results)

Treatment

4. Member's Medical Condition (Continued)

4

Date of Consultation	Y	Y	Y	Y	M	M	D	D

Presenting symptoms and/or complaints

Diagnosis (include blood pressure readings and tests results)

Treatment

5

Date of Consultation	Y	Y	Y	Y	M	M	D	D

Presenting symptoms and/or complaints

Diagnosis (include blood pressure readings and tests results)

Treatment

Was the claimant ever hospitalised or admitted to a medical institution over the past 12 months? ☐ Yes ☐ No

Date of Admission	Y	Y	Y	Y	M	M	D	D

Date of Discharge	Y	Y	Y	Y	M	M	D	D

Reason or Symptoms on Admission

Institution / Hospital

Treatment details (Include operations or procedures)

Final diagnosis (include results of tests done)

4. Member's Medical Condition (Continued)

Date of Admission	Date of Discharge
Y Y Y Y M M D D	Y Y Y Y M M D D

Reason or Symptoms on Admission

Institution / Hospital

Treatment details (Include operations or procedures)

Final diagnosis (include results of tests done)

Date of Admission	Date of Discharge
Y Y Y Y M M D D	Y Y Y Y M M D D

Reason or Symptoms on Admission

Institution / Hospital

Treatment details (Include operations or procedures)

Final diagnosis (include results of tests done)

4. Member's Medical Condition (Continued)

Date of Admission	Date of Discharge
Y Y Y Y M M D D	Y Y Y Y M M D D

Reason or Symptoms on Admission

Institution / Hospital

Treatment details (Include operations or procedures)

Final diagnosis (include results of tests done)

Date of Admission	Date of Discharge
Y Y Y Y M M D D	Y Y Y Y M M D D

Reason or Symptoms on Admission

Institution / Hospital

Treatment details (Include operations or procedures)

Final diagnosis (include results of tests done)

4. Member's Medical Condition (Continued)

Please give us the details of any other doctors or specialists the member saw over the past 12 months:

Doctor

Hospital, Clinic, Medical Institution

Practice Address

Code

Date (Y Y Y Y M M D D)

Contact Number

Doctor

Hospital, Clinic, Medical Institution

Practice Address

Code

Date (Y Y Y Y M M D D)

Contact Number

Doctor

Hospital, Clinic, Medical Institution

Practice Address

Code

Date (Y Y Y Y M M D D)

Contact Number

Doctor

Current symptoms and complaints:

4. Member's Medical Condition (Continued)

For the clinical examination details, please note the clinical findings under the standard medical examination headings for example height, weight, and blood pressure reading.

Results of special investigations for example blood test results, CD4 count results, scan reports, x-ray reports etc. Please include these when you return the form to Triarc Group Risk.

Current treatment and response to treatment. Please specify dosages and comment on the treatment compliance:

Side effects, please specify:

Are you planning any further treatment?	☐ Yes	☐ No

4. Member's Medical Condition (Continued)

Is the member undergoing any form of rehabilitation?		Yes		No

What is the prognosis?

Will He/She be Able to Return to Work?		Yes		No
Will He/She be Able to Preform their Duties?		Yes		No
Is the Member Motivated to Return to Work		Yes		No

5. Declaration

I hereby declare that I have personally examined and attended to the claimant and that the contents of this report are true and correct.

Signed at	Date
	Y Y Y Y M M D D

Signatory First Name(s) and Surname

Doctor's Stamp	Signature