momentum
employee benefits

Application for Disability Benefits

Statement by Attending Specialist

Attending specialist to complete this form

Note: Please attach copies of any recent test results and/or reports.

The request for completion of this form in no way constitutes an admission of liability by the insurer/trustees.

Claimants name

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

The claimant has applied for an insurance benefit. To assess the applicant's state of health we require your assistance with the completion of the questions below. Unfortunately we are unable to begin the assessment of the disability claim until we receive this information.

1. The following proof of identity has been presented

RSA ID Yes ☐ No ☐ ID/Passport No.

2. Are you the applicant's attending specialist? Yes ☐ No ☐

If yes, how long have you acted in this capacity?

Are you aware of the applicant having consulted any other medical person in the last two years and if so, who and when?

Medical Practitioner	Date	Reasaon
	D D - M M - 2 0 Y Y	
	D D - M M - 2 0 Y Y	
	D D - M M - 2 0 Y Y	

3. How frequently do you see the applicant?

When last did you see the applicant, excluding today? D D - M M - 2 0 Y Y

4. Please give details of the illness/accidents for which you have attended to since he/she was refered to you in the last two years?

5. When were you first consulted in connection with the current impairment? D D - M M - Y Y Y Y

6. In your opinion what was the last date that the applicant was last actively able to work? D D - M M - Y Y Y Y

7. Descibe in detail the nature and extent of the applicant's impairment

8. Give dates and outcome of any tests/investigations done to diagnose/quantify the appicant's condition and please enclose copies of any reports/ investigations done

9. Quantify fully the specific changes in function caused by the applicants impairment

(continued)

10. State whether any of the following contributed to the applicant's disablement

Previous illness/injury or personal habits	Yes ☐	No ☐
Wilful self-injury	Yes ☐	No ☐
War or civil commotion or any associated actions	Yes ☐	No ☐

If yes, give details

11. Please describe the previous and current treatment (including dosage and duration) that the applicant has received/is receiving for his/her impairment. Refer to medication, hospitalisation, counselling, physiotherapy, etc:

12. In your opinion is the treatment optimal and is the applicant compliant with the recommended treatment? Yes ☐ No ☐

If no, suggest possible alternative therapy, medication, rehabilitation or surgery that may be attempted to maximise managment

13. Has the condition stabilised or regressed since onset?

14. Provide the short term and long term prognosis of the applicant with supporting reasons

15. In your experience, can you give an indication of the expected recovery period necessary for this applicant?

16. In your opinion is the condition one that will benefit from any form of active rehabilitation? Yes ☐ No ☐

If yes, your suggestions would be appreciated

17.1 Please specify why, in your opinion, the applicant is finding it difficult to perform his/her current occupation and which specific functions of his/her occupation he/she cannot perform?

17.2 What functions can the applicant perform?

17.3 Your medical opinion on the applicant's ability to perform another occupation or his/her own occupation with reasonable accomodations

To facilitate payment print your name and postal address below:

D R

PRACTICE NO.

Tel No:

Fax No:

Email:

Signature of Member

D D - M M - 2 0 Y Y

Date

Consent Form

I, the above signed,

authorise Momentum (the Insurer) to provide medical information that I have supplied to any other person who, in the opinion of the Insurer, is involved in the assessment of the Claimant's disability. I further authorise the insurer to use this information should it be required for legal proceedings.

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