LIBERTY

In it with you

Liberty Health Cover Medical Questionnaire

FOR OFFICIAL USE ONLY Policy number

1. PERSONAL DETAILS OF PRINCIPAL MEMBER

Last name

First name(s) Title

Initials

2. PERSONAL DETAILS OF PATIENT

Last name

First name(s) Title

Initials Date of birth (Y Y Y Y M M D D)

3. MEDICAL INFORMATION REQUIRED

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

a. Name of medical condition/s:

b. What **date did you first consult** with the patient for this condition/symptom? (M M Y Y Y Y)

c. Please confirm the **date of your first treatment** or recommended treatment for this condition/symptom (M M Y Y Y Y)

d. Please confirm the **date the patient first presented with symptoms** for this condition? (M M Y Y Y Y)

e. Please confirm the **date of diagnosis** for this condition? (M M Y Y Y Y)

f. Do you know if the patient consulted with any other healthcare provider prior to the first consultation with you about this condition? Y N

g. If yes, please provide the relevant healthcare provider's contact details

Provider's first name

Provider's last name

Providers work number (include country and area code) +

Provider's mobile (include country and area code) +

Provider's Email

If yes to question f., what treatment did this healthcare provider recommend for the condition/s?

LIBERTY HEALTH COVER
3856 LH23 | Medical Questionnaire | V03 | 03.11.2023

ACKNOWLEDGEMENT BY ATTENDING MEDICAL PRACTITIONER

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

I confirm that the information provided in this questionnaire, is true, correct and complete and that I have not withheld, concealed or misstated any information.

Provider's last name

Provider's first name(s)

Provider's signature

Date Y Y Y Y M M D D

4. DECLARATION BY THE PATIENT/PRINCIPAL MEMBER

Please read the declaration below, then provide your full name and signature below. If the patient is a minor, this section should be completed by the Principal Member.

a. I confirm that I have the necessary authorisations to disclose the information that the Insurer may require and provide the necessary authorisations in respect of my nominated dependant(s).

b. I confirm that the information provided in this application, and in any other documents submitted in support of this application, is true, correct and complete and that I have not withheld, concealed or misstated any information, including any information that the Insurer should know to assess my eligibility to receive health insurance.

c. I irrevocably authorise any medical practitioner, hospital, medical institution, or other person to disclose information about my own, or my nominated dependants' health status to the Insurer or any entity contracted by the Insurer in order to fulfil its functions, duties and obligations in terms of this agreement and I agree that this authorisation shall remain in force after my/their death(s).

d. I authorise the Insurer to collect, process and share my personal information and that of any nominated dependants(s) with any entity, including any foreign entity, contracted by the Insurer in order to fulfil its functions, duties and obligations in terms of this agreement, agree that this authorisation shall remain in force after my/their death(s) and understand that this may partially limit my/their right to privacy.

I

hereby provide consent to my Attending Medical Practitioner to provide the necessary information as requested herein.

Signed at _____ on this_____day of _____20___

Signature of patient/Principal Member _____