• MEDICAL CERTIFICATE REQUEST FORM •

Real People Assurance Company Limited is a registered Financial Services Provider (FSP 26634)
Reg. No. 2001/028918/06 | Real People Views | 12 Esplanade Road | Quigney | East London | 5201
P.O. Box 19610 | Tecoma | 5214
HELPDESK 086 111 4803 | FAX TO 086 623 4080 | E-MAIL realinsuranceclaims@realpeople.co.za

for REAL PEOPLE®

THIS FORM IS TO BE COMPLETED BY THE POLICYHOLDER'S TREATING MEDICAL SPECIALIST/PHYSICIAN ONLY

Policyholder Name

Policy Number

ID Number

1. Are you the policyholder's treating Medical Specialist? Y N
2. Date of diagnosis of the cancer D D M M Y Y Y Y
3. Please describe the nature and extent of the claimants' cancer including relevant staging:
4. Please provide details of treatment (current and projected):
5. Please supply details of radiological, histological and laboratory evidence as well as any other tests on your records:
6. General comments:

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DECLARATION

I, _____ (Full names of Medical Specialist)
do hereby declare that the above statement is true and correct to the best of my knowledge, and that no information has been withheld, nor has any relevant information regarding the circumstances been omitted.

Signed at (place) | On (date) D D M M Y Y Y Y

Physical Address

Area Code

Postal Address

Postal Code

Work No.

Cell No. | Fax No.

E-mail address

Qualifications

Practice Number

HPCSA Number

SIGN HERE

Signature of Medical Practitioner

MEDICAL SPECIALIST STAMP

Please provide us with all histological and diagnostic reports in your possession in order to facilitate a timeous response to this claim.