Capital Alliance
Group Risk
A member of LIBERTY

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KEYRISK GROUP BENEFITS

Claim for Critical Condition Benefit
Confidential Neurologist's Report

CAL Clms HBR stroke

Tick where applicable

To be completed by the attending neurologist or neurosurgeon

Please use a black pen and block letters

Stroke

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth _____

Liberty Group Risk has received an application from the abovementioned to assess a potential benefit against the occurrence or diagnosis of the above medical condition. It is therefore imperative that this form is completed as comprehensively as possible and returned, **together with all the supporting clinical evidence**, to Liberty, P O Box 2094, Johannesburg, 2000 or faxed to (011) 408 2264 or emailed to info@grouprisk.co.za

Definition

In terms of the policy conditions:

Any cerebrovascular incident producing neurological sequelae lasting more than 24 hours including infarction of brain tissue, haemorrhage or embolisation from an intra or extra cranial source. A neurologist or neurosurgeon must confirm evidence of a permanent neurological deficit after the event (prior to which no claims can be admitted).

Excluded are transient ischaemic attacks, migraines, vascular disease affecting the eye or optic nerve or cerebral injury resulting from trauma or systemic hypoxia.

1. When were you first consulted for this condition?

2. Describe in full how the diagnosis was established? (Please ensure that copies of all investigative tests. i.e. CT scan, MRI scan, etc. and reports conducted to confirm the diagnosis are enclosed).

3. Final diagnosis.

4. On what date was the diagnosis made?

5. Are you aware of any factors in the claimant's family history which would have increased the risk of a stroke?

6. Are you aware of whether the claimant has previously suffered from the condition or any associated illness such as hypertension, TIA, ischaemic heart disease or any other vascular disease? If "Yes", please supply:

Date	Reason for consultation	Diagnosis	Treatment	Result/prognosis

7. Please comment on any neurological sequelae which lasted more than 24 hours.

8. Are these sequelae permanent? ☐ Yes ☐ No

9. Was surgery recommended for cardiovascular disease? If "Yes", please provide full details.

NB. Have you enclosed copies of:

- MRI scan report ☐ Yes ☐ No
- CT scan report ☐ Yes ☐ No
- Any other clinical/ diagnostic evidence ☐ Yes ☐ No

Doctor's name and address (please print).

Telephone number _____ Fax number _____

Cellular number _____ Practice number _____

Email address _____ Date

Qualifications _____

I declare and warrant that all information provided by me in this confidential medical report is complete and true. I accept full responsibility for any inaccuracies or omissions contained in this confidential medical report and I understand that the Insurer may bring criminal or civil charges against me in the event that any such inaccuracies or omissions are discovered by the Insurer.

Doctor's signature _____

Please note **The request for completion of this form in no way constitutes an admission of liability by Liberty**

The cost of completing any medical report/s must be borne by the claimant.

Thank you for your assistance