

Please print in block letters using black or blue ink.

Please return completed form to:

Group Assurance
PO Box 1659
Cape Town 8000

OR

Fax to:

021 509 0731

Dear Doctor

Please perform the examination specified below on this Life to be Covered.

1. OFFICE DETAILS

Full name of applicant	<input type="text"/>
Date of birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Scheme code	<input type="text"/>

2. INSTRUCTIONS FOR MEDICAL EXAMINATIONS

<input type="checkbox"/> Cholesterol (3.2.7)	<input type="checkbox"/> Blood Glucose (3.2.24)
<input type="checkbox"/> Chemical and micro urine (3.1.1)	<input type="checkbox"/> HbA1c (3.2.10)
<input type="checkbox"/> Gamma GT (3.2.19)	<input type="checkbox"/> HIV (AIDS test)
<input type="checkbox"/> AST (SGOT) (3.2.19)	<input type="checkbox"/> Blood profile – HIV, Cholesterol, Random Blood Sugar, Gamma
<input type="checkbox"/> ALT (SGPT) (3.2.19)	<input type="checkbox"/> Other tests/examinations <input type="text"/>

For pathological investigations, please draw the specimens required and despatch them together with pages 1 and 2 of this form to the pathology laboratory of your choice.

3. FURTHER INSTRUCTIONS IF AN HIV TEST IS REQUIRED

- 3.1 Please make sure that the Life to be Covered has read the Informed Consent Document on pages 3 and 4, which informs him/her about HIV and AIDS, the reasons for the HIV test and the implications of the test.
- 3.2 Should the Life to be Covered for any reason be unable to read the attached Informed Consent Document, you have an obligation to explain it to him/her and make sure that he/she understands it and consents to the test.
- 3.3 **The Life to be Covered must complete and sign Section A, Informed Consent to HIV Antibody Testing, on page 2.**
- 3.4 Please complete and sign sections B and C of the Informed Consent Document on page 2.
- 3.5 Please draw the blood sample and despatch it together with this form to the pathology laboratory of your choice.
- 3.6 Please give the tear-off portion consisting of pages 3 and 4 to the Life to be Covered.

Note: Failure to follow these procedures precisely will result in the pathology laboratory not performing the HIV TEST.

4. TRANSMISSION OF REPORTS (must always be completed by the intermediary even if only a medical examination is required)

The pathology reports and confirmation of the Life to be Covered's identity MUST be sent to the Chief Medical Officer at the following address: **Dr PJ Bond, Chief Medical Officer, Old Mutual, PO Box 66, Cape Town 8000, South Africa.**

5. CONFIDENTIALITY

Reports are the property of Old Mutual. Reports that are not transmitted electronically must only be posted directly to the Chief Medical Officer at the appropriate address as stated in section 4 above. Under no circumstances may a copy of the results be provided to any doctor, intermediary or other company.

Thank you for your professional services.



Dr PJ Bond
Chief Medical Officer

SECTION A TO BE COMPLETED BY LIFE TO BE COVERED

A. INFORMED CONSENT TO HIV ANTIBODY TESTING (Need only be completed if an HIV test is done)

NB: PLEASE READ PAGES 3 & 4 BEFORE COMPLETING THIS SECTION

- I understand the information contained in the attached two-page Informed Consent Document (i.e. pages 3 and 4).
- I freely consent to the withdrawal of blood from me.
- I freely consent to the testing of that blood.
- I understand that the results of my tests will be kept confidential, except for the disclosure of any reactive result to the doctor whom I have named below.
- I have read the information on this form about what a test result means.
- I understand that I should contact my nominated doctor for further information and counselling if required.
- I understand that Old Mutual will pay for one session of post-test counselling with a doctor of my choice, if I desire it, and if the test result is positive.
- I understand that I have the right to request and receive a copy of this form.
- I understand that details of a positive test result will be held confidentially by the LOA on its register.

Name of nominated doctor/clinic [Grid]

Address [Grid] Postal code [Grid]

Signature of person being tested [Signature Box]

Date [D][D][M][M][Y][Y][Y][Y]

SECTIONS B & C TO BE COMPLETED BY THE PERSON DRAWING THE SAMPLE

B. IDENTIFICATION OF LIFE TO BE COVERED FOR ALL PATHOLOGICAL TESTS (Must always be completed)

Identity number of person being tested [Grid]

Name of person being tested [Grid]

Address [Grid] Postal code [Grid]

C. IDENTIFICATION OF AND DECLARATION BY PERSON DRAWING SAMPLE (Must always be completed)

Name of person drawing sample [Grid]

Practice number [Grid]

Address [Grid] Postal code [Grid]

I have satisfied myself that the person being tested has received the Informed Consent Document, and I have verified the identity of the Life to be Covered and that he/she has freely consented to have the sample drawn and tested for HIV antibodies.

In compliance with the provisions of the LOA HIV Testing Protocol, I have inspected the following document to verify the identity of the Life to be covered:

- valid South African identity document
- valid South African passport
- valid temporary South African identity document
- foreign passport

Signature of person drawing the sample [Signature Box]

Date [D][D][M][M][Y][Y][Y][Y]

Scheme code [Grid]

