2nd Floor Lakeside Office Park, 263 West Street, Centurion, P.O. Box 11962,Centurion, 0046 Tel: (012) 683-1400, Fax: (012) 663-4345/9157

PHS CONSENT FORM FOR DISABILITY CLAIMS

Name of Claimant:…………………………………………………………………………

Age:…………………………………………………………………………………………….

Salary Number:……………………………………………….…………………………….

Occupation:……………………………………Division:………………………………..

I hereby give consent to the South African Post Office (Pension Fund) and its appointed service provider Pro-Active Health Solutions (PTY) Ltd to obtain any relevant medical information directly from my health service providers (i.e. Doctors, Therapists, etc).

This medical information will be used for the sole purpose of evaluating my health status and thereby my capacity to perform occupational duties.

Signature of Claimant…………………………………………..….Date:……………….

Signature of witness……………………………………………Date:……………….

PHS/SAPO cf0900