

IL009 – The Hospitalisation Claim (By Medical Attendant)

Policy no. _____

Full names of life insured _____

Patient Details

Full names _____

Date of birth _____

Contact no. (H) _____ (W) _____ (C) _____

Postal address _____

Email address _____

Industry sector _____

Source of wealth _____

Occupation _____

Family Doctor Details

How long have you been the patient's Doctor?

Date from _____ to _____

If less than 24 months, state previous Doctor's details

Full names _____

Postal address _____

Contact no. (T) _____ (C) _____

Reason for Hospitalisation

☐ Illness or disability

☐ Pregnancy

☐ Accident

Details of Illness

Nature of illness or disability _____

When did patient become aware of illness? _____

Has patient suffered from this condition before?

YES ☐ NO ☐

If yes, give dates and details of treatment _____

Details of Pregnancy

Approximate date of conception _____

Date of delivery _____

Details of Accident

Date of accident _____

Details of accident _____

Injuries sustained _____

Was Hospitalisation in any way Connected to any of the Following?

- | | |
|--|---|
| ☐ Congenital abnormalities | ☐ Self-inflicted injury or attempted suicide |
| ☐ Chronic defects or conditions | ☐ HIV or AIDS related conditions or illness |
| ☐ Mental diseases or disorders | ☐ Miscarriage, abortion or any complications there from |
| ☐ Abuse of alcohol | |
| ☐ Drugs not administered on or in accordance with advice of a doctor | |

Details _____

Declaration by Medical Attendant

I hereby declare that this questionnaire and the statements made above are true and correct in every respect.

I, _____ (full names of Medical Attendant) certify to the correctness of the above-mentioned facts and understand that the fees for this report will be paid on receipt of the original invoice by Holland Specialist Life Limited in accordance to the tariff laid down of the South African Medical Council and the Association Savings and Investment South Africa (ASISA).

Signed at _____ this _____ day of _____ 20 _____

Postal address _____

Qualifications _____

Contact no (W) _____ (C) _____

Medical Attendant or Medical Institution stamp

Signature of Medical Attendant

Representative of Medical Institution

Hollard Declaration:

We respect and adhere to patient confidentiality and data privacy principles in relation to Personal Information. We will therefore only process this information for the purpose for which it is intended.

All claims against the policy must be lodged with Hollard Specialist Life Limited within 30 (thirty) days of the event giving rise to a claim and within 6 (six) months after this notification all the relevant documentation and details of the claim (in writing) together with all documentation supporting the claim must be forwarded to Hollard Specialist Life Limited. No claim shall be considered more than 6 (six) months after the claim event.

Hollard Specialist Life Limited reserves the right to request any additional documentation which it deems necessary for the assessment of the claim. No claim shall be considered under this policy if you are not able to furnish documentation acceptable to Hollard Specialist Life Limited as positive verification of the claim and the facts giving rise to it.

THIS FORM MUST BE ACCOMPANIED BY A COPY OF THE HOSPITAL ADMISSION OR DISCHARGE CHART.

Please provide us with any reports or information in your possession to evaluate the patient's condition.