Hospital Claim Form

To be completed by the Policyholder

The issue of this form does not constitute an admission of liability under the policy. Should this claim be approved, the payment will automatically be credited to the account from which the premiums are collected, unless that account is a credit card account, in which case an alternative account number should be provided. If payment is to be credited to an alternative account, please provide the relevant details.

Policyholder

Policy number _____ Reference number _____

Name of Insured: _____

Postal address: _____

_____

Email address: _____

Telephone No: (H) _____ (B) _____

Cellular No: _____

Fax No: _____

Patient

Name of Patient: _____

Date of birth/Identity Number: _____

Relationship to Policyholder: _____

Occupationent date _____

General Practitioner (usual family doctor)

Name: _____

Postal Address: _____

_____

Cellular No: _____

Telephone No:_____

Fax No: _____

Hospital

Please attach copies of the hospital account and day to day hospital records

Name of hospital: _____

Tel and Fax No: _____

Admitting Doctor: _____

Tel and Fax No: _____

Admission Date: _____ Time: _____

Discharge Date: _____ Time: _____

Reference number _____

Was hospitalisation due to an accident or sickness? _____

Was the accident reported to the relevant authority, if so please provide the case number _____

If sickness, when did symptoms first appear? _____

If pregnancy, approximate date of conception and date of delivery_____

_____

If injury, when did the accident occur? _____

Describe the circumstances surrounding the accident? _____

_____

_____

_____

When did you first consult a doctor for this condition? _____

Is the patient on a medical scheme? (If yes, please supply name and medical aid number

_____

Does the patient have any other Hospital Insurance policies? If yes, please supply Company name and policy numbers

_____

Banking Details

Account Number _____

Account Holders name _____

Name of bank _____

Type of account _____

Branch Name _____

Branch Code _____

Should banking details stated above differ from that of your debit order please submit a bank statement/cancelled cheque with your claim form I declare that the information given is true and complete to the best of my knowledge and belief and authorise any hospital, physician or other person who has attended to me or the patient to furnish Hollard or it's representatives any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital records, including the results of all tests undergone by me or the patient. I agree that a photocopy of this authorisation shall be considered as effective and as valid as the original.

Signed: _____ Date: _____