Hollard.
accident & health

CLAIM FOR MEDICAL EXPENSES

- The issue of this claim form does not imply an admission of liability by the Company.
- The policyholder is responsible for the payment of any fees in connection with the completion of this form
- Only a fully completed and signed claim form can receive our further attention
- The claim form and medical certificate must be completed and returned within sixty days of the accident which gives rise to the claim.
- If medical accounts have been submitted to medical aid for settlement, copies of the accounts and the medical aid statement should be submitted.
- If the patient is not covered by medical aid, the original medical accounts must be submitted

Policy Number …… Effective Date of policy …….

Full name of patient…..……
Date of birth ……
Name of policyholder …….
Postal address ……..
…… Telephone number (daytime) …….

Date of accident ……
Details of accident ……...
……..

Name and address of doctor consulted: ……...
……...

Name and address of regular family doctor ……
……...

Policyholder's Banking Details (for electronic payment of claim)
Bank …… Branch Code …… Account number …….....
Account Holder's name …….

DECLARATION

I hereby declare and warrant that the information given in this claim form is in every respect complete and true.

I authorise any medical practitioner, hospital or other person to provide Flexible Accident & Sickness Acceptances with any information they may require relating to the medical history of the student who is the

subject of this claim and the injury or illness to which this claim relates. I agree that this consent shall remain in force at all times, and that a photo-copy or fax of this declaration shall be accepted as the original.

Signed (patient) ……..…….…… Date ……..

MEDICAL CERTIFICATE

To be completed at the policyholder's expense by the principal medical practitioner attending to the patient.

Patient's name ……
Date of birth …… Height ……. Weight …….

What was the nature of the injury? …….
…….
…….

What operation, if any, was performed ……..
…….

When did you first treat the patient for this injury …….. ……..
Has the patient suffered from this condition or a related condition before? Yes/No
If yes, please give details ……
…….
…….

Are you the patient's regular/family doctor? Yes/No

Was the patient's treatment in any way connected with the following:

Use of drugs (other than administered by a doctor) or alcohol Yes/No
Suicide or self-inflicted injury Yes/No
HIV or AIDS Yes/No
Dental treatment Yes/No
Cosmetic or plastic surgery Yes/No
Congenital abnormality Yes/No

If the answer to any of the above is Yes, please give details ……..
……..
……..

MEDICAL PRACTITIONER'S DETAILS

Name ……. Qualifications …….
Postal Address ……
……... Telephone number ……..
Signature ……... Date……..