# HOSPITAL CLAIM FORM

For more information on the benefits or claim procedures please contact PSG Konsult on 0860 100 296 or msu@psgkonsult.co.za
PSG Konsult (Pty) Ltd is an authorised financial service provider

COMPANY NAME:
POLICY NUMBER:
SURNAME:
FIRST NAMES:
ID NUMBER:

**PLEASE FAX THIS APPLICATION FORM TO: 086 688 5285**

## POSTAL ADDRESS

## PHYSICAL ADDRESS (IF

## TELEPHONE NUMBERS

TELEPHONE NUMBER WORK:
TELEPHONE NUMBER HOME:
CELLPHONE NUMBER:

## PARTICULARS OF CLAIMANT (PATIENT)

SURNAME:
FIRST NAMES:
DATE OF BIRTH:
ID NUMBER:

| MALE | FEMALE |
|---|---|

## RELATIONSHIP TO MEMBER

| SELF | SPOUSE | CHILD | OTHER |
|---|---|---|---|

**IS THIS CLAIM IN RESPECT OF A DEPENDANT CHILD OVER THE AGE OF 18?**

| YES | NO |
|---|---|

**IF YES, PLEAE ATTACH DETAILS OF THE SCHOOL, COLLEGE OR UNIVERSITY ATTENDED BY THE DECEASED AND/OR PROOF THAT THE CHILD WAS TOTALLY DEPENDANT ON THE PRINCIPAL MEMBER.**

***CLAIM FORM CONTINUED…..***

## PAYMENT INSTRUCTIONS

ACCOUNT HOLDERS NAME:

ACCOUNT NUMBER:

BANK/BUILDING SOCIETY:

BRANCH CODE:

ACCOUNT TYPE CURRENT ☐ TRANSMISSION ☐ SAVINGS ☐

SIGNATURE OF ACCOUNT HOLDER: ______________________________

CAPACITY ______________________________

**NOTE:**
**BENEFIT AMOUNT PAYABLE TO NOMINATED BENEFICIARY'S ACCOUNT ONLY. NO THIRD PARTY PAYMENTS ALLOWED.**

## DETAILS OF CLAIM

DIAGNOSIS

HOSPITAL NAME

DATE ADMITTED DATE DISCHARGED

TYPE OF WARD WARD NAME

PATIENTS HOSPITAL NO TEL EXT

WAS PATIENT CONFINED TO ICU Y N DATE FROM DATE TO

WAS HOSPITALISATION A RESULT OF AN ACCIDENT / INJURY Y N

DATE OF ACCIDENT / INJURY

NATURE OF ACCIDENT / INJURY

POLICE STATION REPORTED CASE NO

DID HE/SHE HAVE ANY TREATMENT FOR THIS DISEASE / ILLNESS IN THE LAST 12 MONTHS Y N

IF YES, STATE DATE

IS THERE ANY REASON TO BELIEVE THAT THE INSURED PERSON'S ILLNESS IS IN ANY WAY DUE TO OR ARISES DIRECTLY OR INDIRECTLY FROM AIDS OR HIV INFECTION Y N

IF YES, STATE RESULTS OF TEST

***CLAIM FORM CONTINUED….***

***Was hospitalisation connected in any way to a mental disease or disorder, use of alcohol, the influence of any drug not administered on the advice of a doctor, injury or illness caused through intentional self-infliction or sexually transmitted diseases?***

***If YES, give details***

***In the case of a female, was hospitalisation due to pregnancy, childbirth, miscarriage, abortion or complications thereof?***

***If YES, give details***

***DECLARATION BY ATTENDING DOCTOR***

***I hereby certify that the person hospitalised, as named in this form, was suffering from the injuries / illness referred to in this form and I know of no circumstances, other than the aforementioned, which might effect the assessment of the claim, if any, in respect of the person insured.***

***Signed at this day of 20***

**SIGNATURE OF DOCTOR:** ______________________

**DOCTOR NAME** ______________________

**HOSPITAL NAME:** ______________________

**TEL NUMBER:** ______________________

## DECLARATION

1. **I/We declare that the person mentioned under patient details is nominated under the abovementioned policy, that all the particulars given are true and complete, and that the illness was not wholly or partly, directly or indirectly, caused by the contingencies mentioned in the General and Specific exceptions attached to the policy in question.**
2. **I/We further declare that the above statements are true and that I/We have withheld no material information and that I/we undertake to furnish any documentation which may be required by PSG Konsult.**
3. **I/We expressly waive all provisions of law, custom or professional etiquette forbidding any physician or other person who attended or examined the claimant, or any institution in which the deceased received treatment, to disclose any knowledge or information which was thereby acquired and agree that this authority shall remain in force until cancelled in writing.**
4. **I/We authorise all such persons or agencies to furnish any information in their possession to PSG Konsult.**

______________________________________________

**APPLICANT (NAME AND SURNAME)**

**SIGNATURE** ______________________

**DATE:** ______________________

## ***PLEASE ATTACH:***

**HOSPITAL ACCOUNT / LETTER STATING DATE OF ADMISSION, DISCHARGE AND DIAGNOSIS, SIGNED BY THE DOCTOR**
**CERTIFIED COPY OF MAIN MEMBERS ID**
**CERTIFIED COPY OF ID OF MEMBER IN HOSPITAL**
**HOSPITAL STAMP**
**DOCTOR'S SIGNATURE**

## ***PLEASE RETURN TO:***

**PO Box 25149**
**Gateway**
**4321**

**OR Fax to:**

**086 688 5285**