

HOSPITAL CASH BENEFIT CLAIM FORM



1. Please attach hospital invoice receipt or an original, stamped certificate from the hospital reflecting dates hospitalized, reason for hospitalization, patient's file number and type of ward.
2. Please attach copies of claimant's ID and ID of the person hospitalized, or if a child, a birth certificate or record.

1. PERSONAL INFORMATION

Surname of policy holder:	<input type="text"/>	First Names:	<input type="text"/>
Policy number:	<input type="text"/>	Company/paypoint name:	<input type="text"/>
Residential address:	<input type="text"/>		
Postal address:	<input type="text"/>		
Telephone number:	<input type="text"/>	Occupation:	<input type="text"/>

2. DETAILS OF HOSPITALISATION

Hospital to which admitted:	<input type="text"/>		
Name of ward:	<input type="text"/>	Patient's hospital file no.:	<input type="text"/>
Reason for hospitalisation:	<input type="text"/>		
Date admitted:	<input type="text"/>	Date discharged:	<input type="text"/>
Was hospitalisation a result of accident or injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date of accident/injury: <input type="text"/>
Nature of injury:	<input type="text"/>		
Was patient confined to I.C.U?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, date confined to I.C.U from	<input type="text"/>	to	<input type="text"/>
When did he/she become aware of the complaint, illness or disease?	<input type="text"/>		
Did he/she have any treatment for this disease/illness in the last twelve months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, please give details:	<input type="text"/>		

Payment Details

Name of Account Holder	<input type="text"/>		
Bank Name	<input type="text"/>	Branch Name	<input type="text"/>
Account Number	<input type="text"/>	Branch Code	<input type="text"/>
Account type	<input type="checkbox"/> Current Account	<input type="checkbox"/> Savings Account	<input type="checkbox"/> Account/Other (Specify) <input type="text"/>

If we receive premiums after cancelling your policy, we will pay the premiums to this account.

3. ADDITIONAL INFORMATION

Was hospitalization connected in any way to any of the following?

- Mental disease or disorder, excessive use of alcohol, the influence of any drug not administered on the advice of a doctor, injury or illness caused through intentional self-inflicted and sexually transmitted disease, any violation of the criminal law, the result of any insurrection, civil commotion, war, participation in any speed contests, cosmetic surgery including obesity, active participation in mountaineering, horse riding, hunting, power boat racing, motor racing, etc.

Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please give details: <input type="text"/>
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• In case of a female, was hospitalization due to pregnancy, childbirth, miscarriage, abortion or any complications there from?

Yes		No	If yes, please give details:	

Was the illness or injury sustained while the person assured was resident overseas? Yes No

4. DECLARATION BY POLICY OWNER

I, the undersigned, hereby declare that the above particulars are true in every respect and made without reservation. I further irrevocably authorize any doctor or any other person who has attended to me or my relatives, or any other hospital or other institution which has medical information about me or my relatives to disclose such information to Sanlam Life Insurance Company Zambia Ltd and agree that this authority shall remain in force after my death.

Signed at	<input type="text"/>	Date	<input type="text"/>
Signature of patient (if not policy owner)	<input type="text"/>	Signature of policyholder	<input type="text"/>

5. DECLARATION BY MEDICAL OFFICER

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

Signed at	<input type="text"/>	Date	<input type="text"/>
Signature of medical attendant	<input type="text"/>		

Name in block letters:	<input type="text"/>		
Qualifications:	<input type="text"/>		
Telephone number:	<input type="text"/>	Fax number:	<input type="text"/>
Address:	<input type="text"/>		

Please place
hospital stamp here

Comments

Signed by

Date