HOSPITAL CASH BENEFIT CLAIM FORM

Sanlam

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:		First Names:	
Policy number:		Company/paypoint name:	
Residential address:			
Postal address:			
Telephone number:		Occupation:	

2. DETAILS OF HOSPITALISATION

Hopspital to which admitted:			
Name of ward:		Patient's hospital file no.:	
Reason for hospitalisation:			

Date admitted:				Date discharged:	
Was hospitalisation a result of accident or injury?:	Yes		No	Date of accident/injury:	
Nature of injury:					
Was patient confined to I.C.U?:	Yes		No		
If yes, date confined to I.C.U from		to			
When did he/she become aware of the complaint, illness or disease?:					
Did he/she have any treatment for this disease/illness in the last twelve months?:	Yes		No		
If yes, please give details:					

Payment Details

Name of Account Holder							
Bank Name					Branch Name		
Account Number					Branch Code		
Account type		Current Account		Savings Account		Account/Other(Specify)	

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		No		If yes, please give details:	

• 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 Issurance Company Zambia Ltd and agree that this authority shall remain in force after my death.

Signed at		Date	
Signature of patient (if not policy owner)		Signature of policyholder	

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		Date	
Signature of medical attendant			

Name in block letters:			
Qualifications:			
Telephone number:		Fax number:	
Address:			

Please place hospital stamp here	

Comments	
Signed by	Date