HEALTHCOR PROJECTS SINCE 1988

Healthcor Projects (Pty) Ltd is an Authorised Financial Services Provider, No. 17862

BARGAINING COUNCIL BCCCI CONTRACT CLEANING SERVICES INDUSTRY KZN

FAMILY *CRISIS PLAN*

HOSPITAL CLAIM FORM

This form MUST be completed and returned to **Healthcor Projects (Pty) Ltd.**
Leli fomu KUFANELWE ligcwaliswe bese libuyiselwa kwa **Healthcor Projects (Pty) Ltd.**

Please send this completed form with all relevant documentation to **queries@healthcorsa.co.za**
For assistance please call Healthcor Projects (Pty) Ltd on 064 922 8489 or 083 278 4680

This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership.

PERSONAL PARTICULARS (PRINCIPAL MEMBER)

SURNAME			
COMPANY NAME		FIRST NAMES	
ID OR PASSPORT NO.			
DATE OF BIRTH	D D M M Y Y Y Y		
TELEPHONE NUMBER	C O D E	POLICY NUMBER	
WORK NUMBER	C O D E	CELLPHONE NUMBER	C O D E

POSTAL ADDRESS	PHYSICAL ADDRESS (IF DIFFERENT)
POSTAL CODE	POSTAL CODE

COMPANY BRANCH		COMPANY SITE	

PARTICULARS OF PATIENT

SURNAME		FIRST NAMES	
ID OR PASSPORT NO.			
DATE OF BIRTH	D D M M Y Y Y Y		

GENDER ☐ MALE ☐ FEMALE

RELATIONSHIP TO MEMBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

IS THIS CLAIM IN RESPECT OF A DEPENDANT CHILD OVER THE AGE OF 21? ☐ YES ☐ NO

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

PAYMENT INSTRUCTIONS

ACCOUNT HOLDER'S NAME			
BANK / BUILDING SOCIETY		ACCOUNT TYPE	☐ CURRENT
ACCOUNT NUMBER			☐ TRANSMISSION
BRANCH CODE			☐ SAVINGS

DATE D D M M Y Y Y Y

SIGNATURE OF ACCOUNT HOLDER

NOTE:

Any benefits payable are to be made into a nominated beneficiary's bank account. No payments to a third party is permitted. Neither Ambledown or Guardrisk will be liable for any losses for payments where incorrect bank details have been provided.

DETAILS OF CLAIM

PATIENT NAME AND SURNAME			
PATIENT ID NO. OR DATE OF BIRTH			
DIAGNOSIS			
ICD 10 CODE			
HOSPITAL NAME			
DATE ADMITTED	D D M M Y Y Y Y	DATE DISCHARGED	D D M M Y Y Y Y
TYPE OF WARD		WARD NAME	
PATIENT'S HOSPITAL NUMBER		TELEPHONE EXTENSION	

WAS PATIENT CONFINED TO ICU	☐ YES	☐ NO	DATE FROM	D D M M Y Y Y Y	DATE TO	D D M M Y Y Y Y	
WAS HOSPITALISATION A RESULT OF AN ACCIDENT / INJURY	☐ YES	☐ NO					
DATE OF ACCIDENT / INJURY	D D M M Y Y Y Y						
NATURE OF ACCIDENT / INJURY							
POLICE STATION REPORTED		CASE NUMBER					
DID HE/SHE HAVE ANY TREATMENT FOR THIS DISEASE / ILLNESS IN THE LAST 12 MONTHS	☐ YES	☐ NO					
IF YES, STATE DATE	D D M M Y Y Y Y						
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?	☐ YES	☐ NO					
IF YES, GIVE DETAILS							

IN THE CASE OF A FEMALE, WAS HOSPITALISATION DUE TO PREGNANCY, CHILDBIRTH, MISCARRIAGE, ABORTION OR COMPLICATIONS THEREOF?	☐ YES	☐ NO
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	
		DATE	D D M M Y Y Y Y
		HOSPITAL NAME	
		DOCTOR NAME	
SIGNATURE OF DOCTOR	HOSPITAL STAMP	TELEPHONE NUMBER	C O D E

DECLARATION BY PRINCIPAL MEMBER

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/injury 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 Ambledown Financial Services (Pty) Ltd (Ambledown).
3. I/We expressly waive all provisions of law, custom or professional etiquette forbidding any physician or other person who attended or examined the patient, or any institution in which the patient 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 Ambledown.
5. I/We consent to Ambledown or its authorised representatives from obtaining and processing my (or my dependants) personal information and I/we understand why my /our personal information is required and the purpose it will be used.
6. I/We acknowledge I/we have the right to request from Ambledown details of any of my personal information Ambledown holds on my/our behalf and details of how my personal information has been processed and to lodge a complaint with the Information Regulator.

SIGNATURE OF PRINCIPLE MEMBER	SIGNATURE OF PATIENT *(if different from the principal member)*

DATE | D | D | M | M | Y | Y | Y | Y |

PLEASE ATTACH

HOSPITAL CLAIMS

Fully completed and claim form stamped by the hospital
Certified ID / birth certificate copies - principle member and patient
Stamped copy of claimant's bank statement
In the case of a dependant child over the age of 21, please attach details of the school, college or university attended by the patient

Broker Details: Healthcor Projects (Pty) Ltd. FSP Number: 17862
Tel: 064 922 8489/ 083 278 4680 PO B ox 1735, Umhlanga Rocks, 4320