HEALTHCOR PROJECTS SINCE 1988

BARGAINING COUNCIL BCCCI CONTRACT CLEANING SERVICES INDUSTRY KZN

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

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 claims@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 Groups R Us or Sanlam or Healthcor Projects (Pty) Ltd 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	TELEPHONE NUMBER	C O D E
	HOSPITAL STAMP	

TAKE NOTE:

"Accident" a sudden, unforeseen, and uncertain event, which could not reasonably be expected to occur, which is caused by violent, external, physical, and visible means at an identifiable time and place, resulting directly and independently of any other cause, in Bodily Injury. This definition shall exclude self-inflicted injury and attempted suicide.

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 Groups Are Us (Pty) Ltd (Groups R Us) / Healthcor Projects (Pty) Ltd .
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 Groups R Us / Healthcor Projects (Pty) Ltd .
5. I/We consent to Groups R Us / Healthcor Projects (Pty) Ltd 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 Groups R Us / Healthcor Projects (Pty) Ltd details of any of my personal information Groups R Us / Healthcor Projects (Pty) Ltd 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 **PRINCIPAL MEMBER**	SIGNATURE OF PATIENT *(if different from the principal member)*

DATE D D M M Y Y Y Y

TO PROCESS YOUR CLAIM SUCCESFULLY PLEASE ATTACH

HOSPITAL CLAIMS
Fully completed and signed claim form stamped by the hospital
Discharge form, with the doctor's details clearly stated.
Certified ID / birth certificate copies - principal 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

TAKE NOTE:

Any information that is not correct/accurate, and that cannot be confirmed by hospital administration or by the doctor(s) that attended to the patient, will be forwarded to the forensics department for investigation. The council/employer will be informed if any fraudulent information is being supplied and case will be reported to SAPS for further investigation.

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

Administered by GROUPS R US INSURANCE PARTNERS

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Underwritten by Sanlam

Healthcor Projects (Pty) Ltd (CIPC Reg No. 1993/006077/07) is an authorised Financial Services Provider (FSP17862) and is underwritten by Sanlam Developing Markets (CIPC Reg No. 1911/003818/06), a licensed Life Insurer and authorised Financial Services Provider (FSP11230). Groups Are Us (Pty) Ltd t/a Groups R Us (CIPC Reg No. 2020/553498/07) is an authorised Financial Services Provider (FSP45735) and the appointed administrator.