

**CLAIM FORM**

**PLEASE SEND ALL CLAIMS TO: 7 Baartman Street  
 PO Box 1462  
 Bethlehem, 9700  
 Fax: 0861 101 574**

**CLAIMS WILL NOT BE PROCESSED WITHOUT ALL ORIGINAL ACCOUNTS ATTACHED**

**CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS FROM DISCHARGE**

**TYPE OF CLAIM**

SAPMEDS CLAIM	<input type="checkbox"/>	GAP COVER CLAIM	<input type="checkbox"/>	PMB+	<input type="checkbox"/>
PREMIUM WAIVER	<input type="checkbox"/>	ESSENTIAL 13	<input type="checkbox"/>	OTHER	<input type="checkbox"/> _____

**PRINCIPLE INSURED**

Surname	<input type="text"/>	Title	<input type="text"/>
First Name(s) <i>(in full)</i>	<input type="text"/>	Initials	<input type="text"/>
ID/Passport Number	<input type="text"/>	Policy Number	MED <input type="text"/>
Patient	<input type="text"/>		
Residential Address	<input type="text"/>		
Postal Address	<input type="text"/>		
E-mail Address	<input type="text"/>		
Telephone (W)	<input type="text"/>	Cell	<input type="text"/>
Telephone (H)	<input type="text"/>	Fax	<input type="text"/>

**ACCOUNT DETAILS**

Account Name	<input type="text"/>		
Bank Name	<input type="text"/>	Branch Code	<input type="text"/>
Account No.	<input type="text"/>	Branch Name	<input type="text"/>
Account Type	<input type="text"/>		

**RESOLUTION UNDERWRITERS MUST BE NOTIFIED (0861 011 123) 48 HOURS PRIOR TO ANY OCCURRENCE WHICH  
 MAY GIVE RISE TO A CLAIM**

**NO FAXED COPIES OF ACCOUNTS WILL BE ACCEPTED**

Signature of Policy Holder: \_\_\_\_\_

Date