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Hospital Cash Plan Claim Form

Kindly answer all questions in full and attach supporting documentation as listed below. Please note that this form should be submitted after the patient who is an Insured Person covered under the plan, has been discharged from hospital or after day 21 in hospital, for longer hospital stays.

SUPPORTING DOCUMENTS FOR THIS CLAIM *(Please attach the following documents)*

- ☐ Certified copy of Policyholder's proof of identity
- ☐ Certified copy of the patient's proof of identity
- ☐ Proof of bank details for beneficiary
- ☐ Hospital Medical records / invoice

Liberty life reserves the right to call for additional documents where necessary in order to validate the claim

Policy number

POLICYHOLDER DETAILS

Surname

First names Gender M F

Identity number Date of birth D D - M M - Y Y Y Y

Telephone number Mobile number

Email address

Postal address

Postal code

PATIENT DETAILS

Is the Life Assured ☐ Policyholder ☐ Spouse ☐ Child

Surname

First names Gender M F

Identity number Date of birth D D - M M - Y Y Y Y

CLAIM PAYMENT DETAILS

CLAIM PAYMENT METHOD

☐ EFT ☐ Cheque

BANK DETAILS FOR EFT PAYMENTS

(Please attach confirmation of account details on the Bank's letterhead or cancelled cheque.)

Name of accountholder

Name of bank

Account number Branch name

Branch code Account type

ADVICE INSURE INVEST

CLAIM DETAILS

HOSPITALISATION DETAILS

Name of Hospital

Hospital address

Hospital telephone number

Fax

Admitting Doctor

Doctor's telephone number

Fax

Primary reason for hospitalisation

Admission date D D - M M - Y Y Y Y Time

Discharge date D D - M M - Y Y Y Y Time

Number of days in ICU, if applicable

Hospitalisation is due to: ☐ Disease/Illness ☐ Accident/injury/trauma

IF HOSPITALISATION IS DUE TO AN ACCIDENT

Date of accident D D - M M - Y Y Y Y Time

Place

Provide details of how the accident occurred

What injuries did you sustain?

Was the accident reported to the police? Y N

Name of police station

Case number

IF HOSPITALISATION IS DUE TO A DISEASE/ILLNESS

Nature and earliest symptoms of the condition

Date of earliest symptoms of the condition D D - M M - Y Y Y Y

When did you first consult a medical doctor regarding the condition? D D - M M - Y Y Y Y Date diagnosis confirmed D D - M M - Y Y Y Y

Prescribed treatment you are currently taking/using

FAMILY DOCTOR'S DETAILS

Medical Practitioner's full name

Postal address

Physical address

Telephone number

Fax

Email address

CLAIMANT'S DECLARATION

I, in my capacity as claimant, hereby certify that the above information submitted by me, is to the best of my belief and knowledge both true and correct. I further confirm that I have not withheld, concealed or misstated any information. I hereby authorize any Medical Practitioner or hospital to furnish Liberty or its appointed representatives with information relating to the patient's illness or injury. I authorize the Insurer to collect and share information. I accept that with this authorization I am limiting my right to privacy. However to assess the insurance risk, I irreversibly authorize the Insurer to obtain from any person, whom I hereby permit and request to give any information which the Insurer needs and share with other Insurers that information and any information in this application or any related source at any time a form approved by the Insurer or the Regulator.

Claimant's name and surname

Claimant's signature

Date D D - M M - Y Y Y Y

MEDICAL CERTIFICATE *This certificate is to be completed by the attending (treating) medical practitioner at the insured's expense*

Name of patient

Policy number

HOSPITALISATION DETAILS

Name of Hospital

Hospital address

Admission date D D - M M - Y Y Y Y Time

Discharge date D D - M M - Y Y Y Y Time

Primary diagnosis for admission

Date of first diagnosis D D - M M - Y Y Y Y Time

Number of days in ICU, if applicable

Additional diagnoses

PRIMARY REASON FOR ADMISSION

- ☐ Acute disease/illness
- ☐ Chronic disease/illness
- ☐ Medical investigation
- ☐ Accident
- ☐ Mental disorder
- ☐ Alcohol or drug use/dependence
- ☐ Treatment of infertility
- ☐ Obesity
- ☐ Elective surgery
- Other (please specify)

IF HOSPITALISATION IS DUE TO AN ACCIDENT

Date of accident D D - M M - Y Y Y Y Time

What injuries did the patient sustain?

Please give details of specific procedures performed

Please give details of treatment prescribed and administered

ACKNOWLEDGEMENT BY ATTENDING DOCTOR

I certify that the above information is, to the best of my knowledge and belief, true and accurate, and that no information has been withheld, nor has any information regarding the circumstances been omitted.

Medical Practitioner's full name

Practice name

Registration number

Doctor's telephone number

Fax

Email address

Medical Practitioner's signature

Date D D - M M - Y Y Y Y