



**DETAILS OF CLAIM**

TYPE OF CLAIM: TARIFF  CO-PAYMENT  PER DAY  OTHER

PLEASE COMPLETE THE FOLLOWING:

DIAGNOSIS

HOSPITAL NAME

TYPE OF WARD

DATE OF HOSPITALISATION FROM  TO

NAME OF ADMITTING DOCTOR

DOCTOR'S PRACTICE NUMBER  TEL NO.

REFERRING DOCTOR (if applicable)  TEL NO.

WAS PATIENT CONFINED TO ICU   FROM  TO

WAS HOSPITALISATION A RESULT OF AN ACCIDENT /INJURY

Date of service	Service provider	Amount charged	Paid by medical aid	Shortfall
YYYYMMDD	<input type="text"/>	R	R	R
YYYYMMDD	<input type="text"/>	R	R	R
YYYYMMDD	<input type="text"/>	R	R	R

**DECLARATION**

(1) I/We hereby declare that the person mentioned under claimant details is nominated under the abovementioned policy, that all the particulars given are true and complete, and that the hospitalisation was not wholly or partly, directly or indirectly, caused by the contingencies mentioned in both the General and Specific exceptions as well as any addendum attached to the policy in question,

**In particular, I'm aware that this claim does not fall into one of the following 3 exceptions:**

1. **Pregnancy or childbirth during the first 12 months of the contract.**
2. **For a period of 12 months from date of inception, any condition for which an insured person received treatment or advice by a Medical Practitioner within a 12-month period prior to the inception date of that insured person, unless such a condition was directly attributable to an Accident (as defined).**
3. **A 3-month general waiting period will apply from date of inception for all procedures other than due to an accident.**

(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 Hollard Group Risk, a division of The Hollard Insurance Company Limited and Hollard Group Risk, a division of Hollard Life Assurance Company Limited.

(3) I/We expressly waive all provisions of law, custom or professional etiquette forbidding any physician or other person who attended or examined the claimant, or any institution in which the claimant 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 Hollard Group Risk, a division of The Hollard Insurance Company Limited and Hollard Group Risk, a division of Hollard Life Assurance Company Limited.

Applicant / Principal Member (Name and Surname)

Signature

Date

**PLEASE ATTACH THE FOLLOWING DOCUMENTS APPLICABLE TO THE DATE OF INCIDENT:**

(Failure to attach all applicable documentation to this claim form will cause undue delay in the processing thereof.)

- HOSPITAL ACCOUNT (FIRST FOUR PAGES ONLY)
- DOCTORS ACCOUNT
- MEDICAL AID STATEMENT (COMPULSORY)

PLEASE RETURN TO:

COMPLIMED  
 PO BOX 658  
 PINETOWN  
 3600  
 TELEPHONE 086 111 4203 & FAX 086 604 6242