

DREAD DISEASE / SEVERE ILLNESS BENEFIT CLAIM FORM

Underwritten by Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

- 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.
- THE MASTER POLICY ISSUED IS THE SOURCE OF ALL BENEFITS, RIGHTS, AND OBLIGATIONS AND EXCLUSIONS. TO DETERMINE YOUR INDIVIDUAL NEEDS, WE SUGGEST THAT YOU CONTACT YOUR BROKER AND REQUEST ADVICE FROM HIM / HER.

CLAIMING PROCEDURES

Claims should be submitted in writing by no later than one hundred and eighty (180) days/six months (6) from the date of diagnosis to; (i.e. complete the claim form as soon as possible).

Ambledown Financial Services (Pty) Ltd
 PO Box 1862, Cramerview, 2060

Tel: 086 126 2533 Fax: 011 463 1665 Email: claims@ambledown.co.za

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

BEFORE ANY CLAIM CAN BE SETTLED, COPIES OF THE FOLLOWING DOCUMENTATION RELATING TO THIS PARTICULAR CLAIM/S ARE REQUIRED:

1. Histology report
2. Oncology Treatment Plan

PRINCIPAL INSURED MEMBER DETAILS

TITLE		SURNAME		INITIALS	
ID NUMBER				POLICY / MEMBER NUMBER	

CONTACT DETAILS

POSTAL ADDRESS	TELEPHONE NUMBER	AREA CODE							
	CELL NUMBER	CODE							
	E-MAIL								
	EMPLOYER								
POSTAL CODE				CONTACT NUMBER	AREA CODE				

FAMILY DOCTOR (GP) DETAILS

NAME	
TELEPHONE NUMBER	AREA CODE

PATIENT DETAILS

FIRST NAMES		MALE		FEMALE				
SURNAME		RELATIONSHIP TO PRINCIPAL MEMBER						
ID NUMBER		SELF		SPOUSE				
		CHILD		OTHER				
MEDICAL SCHEME NAME		MEDICAL SCHEME OPTION		SCHEME NO.				
IS THE CLAIM IN RESPECT OF A DEPENDENT CHILD OVER 21 YEARS OF AGE?					YES		NO	

If Yes, the child should be financially dependent on the principal insured and attach proof that the child is a dependant on the principal's medical aid scheme.

TYPE OF CANCER:	
DATE OF DIAGNOSIS OF CANCER:	

NOTE: ONLY APPLICABLE TO POLICIES WITH THE DREAD DISEASE / SEVERE ILLNESS BENEFIT

TREATING DOCTOR/S DETAILS:

NAME	PRACTICE NO.	DATE OF SERVICE								TELEPHONE NUMBER							
		D	D	M	M	Y	Y	Y	Y	AREA CODE							
		D	D	M	M	Y	Y	Y	Y	AREA CODE							
		D	D	M	M	Y	Y	Y	Y	AREA CODE							
		D	D	M	M	Y	Y	Y	Y	AREA CODE							
		D	D	M	M	Y	Y	Y	Y	AREA CODE							

PAYMENT INSTRUCTIONS

BENEFITS TO BE PAID INTO MY BANK ACCOUNT BY ELECTRONIC FUND TRANSFER, DETAILS BELOW

ACCOUNT HOLDERS NAME		BANK	
ACCOUNT NUMBER		BRANCH	
BRANCH CODE		ACCOUNT TYPE	CURRENT
		(NO CREDIT CARD ACCOUNTS ACCEPTED)	TRANSMISSION
			SAVINGS

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SIGNATURE OF ACCOUNT HOLDER

SIGNATURE OF PRINCIPAL INSURED MEMBER
(If different from account holder)

The company will not be liable for the loss of funds due to the provision of incorrect bank details by the member.

DECLARATION AND MANDATE

I declare that the above particulars are true in every respect and I attach or will forward as soon as possible copies of all required documentation. I hereby authorise any hospital, physician, medical aid or other person who has attended to or examined me or my dependants, to furnish to the company or its authorised representative any information with respect to any illness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital or medical records.

You hereby authorise and mandate us to obtain all necessary information from your Medical Scheme, including but not limited to biographical information, benefit and claim information, and medical information.

This consent and mandate will remain in force until withdrawn in writing.

Except to the extent that we acted with gross negligence or fraudulent intent, you hereby indemnify us and undertake to hold us harmless against any loss, damage, legal liability, legal costs (including costs on an attorney and client scale) or expenses of whatever nature we may suffer or become liable for alleged to arise or arising from the consent and mandate you provided to us in accordance with this Agreement.

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SIGNATURE OF THE INSURED PERSON
(or authorised person)

SIGNATURE OF PATIENT
(If different from the principal insured)

DATE

D	D	M	M	Y	Y	Y	Y
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(If the patient is a minor, the form must be signed by the parent or guardian, who confirms that they are the competent and authorised person to sign on behalf of the minor).

IN CASE OF A MINOR:

NAME OF THE COMPETENT AND AUTHORISED PERSON	
RELATIONSHIP TO THE MINOR PATIENT	

BROKER DETAILS

BROKER NAME																	
TELEPHONE NUMBER	AREA CODE															E-MAIL	

