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 first day of treatment 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

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*

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

PRINCIPAL INSURED MEMBER DETAILS

TITLE		INITIALS		SURNAME	
ID OR PASSPORT NUMBER				POLICY/MEMBER NO	
DATE OF BIRTH	D D M M Y Y Y Y				

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 OR PASSPORT NUMBER		SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	
DATE OF BIRTH	D D M M Y Y Y Y	MEDICAL SCHEME NAME	
MEDICAL SCHEME OPTIONS		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	D D M M Y Y Y Y

☐ ☐

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

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 (NO CREDIT CARD ACCOUNTS ACCEPTED)	☐ CURRENT ☐ TRANSMISSION ☐ SAVINGS

SIGNATURE OF ACCOUNT HOLDER

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

D D M M Y Y Y Y

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 hospital, medical accounts and relevant medical aid statements. 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.
You hereby authorise us to negotiate with and request your Medical Scheme to re-assess your claims, negotiate any discount with the relevant Service Providers on your behalf, pay the benefit payable in terms of the Gap Cover Policy directly to the Service Provider, should a discount be negotiated.
If the benefit available to the Insured Person is greater than the fee charged by the Service Provider, then we will pay the balance of the benefit payable in terms of the Gap Cover Policy to the Insured Person once the Service Provider is paid.
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.

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

(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	

Broker Details: [Brokerage Company Name],
FSP number: [xxxxxxxxxxx]
[Telephone number], [Mobile number], [Website address]