Health Insurance Claim Form

POLICY NUMBER

1. POLICYHOLDER (Company/Individual) Written in BLOCK letters ortyped.

Name (in full)

Address

Family / Member ID

Telephone (Mobile)

Email

2. CLAIMANT / PATIENT (If different from above)

Name (in full)

Home adress

Age

ID Number

Profession or Occupation

Telephone

Telephone (Mobile)

Email

3. ALL QUESTIONS MUST BE ANSWERED OR THE CLAIM WILL BE REJECTED

(ONE claim form per treatment/illness/and per patient)

Claim is for

- ☐ Optical: Glasses, eye correction, optician...
- ☐ Dental: Dentist, Orthodontist...
- ☐ Out-Patient: Consultations, investigations, prescriptions, therapies and treatment
- ☐ In-Patient: Investigations, operations and treatments relating to ONE condition or childbirth.
- ☐ Antenatal care
- ☐ Other

1. Reason(s) for consultation? The symptom(s) or problem(s) that led the Claimant / Patient to seek treatment.

2. Please provide

a) Name, address and Tel No of the doctor who attended you. (If not CLEARLY indicated on the documents.)

b) Treating Doctor's Diagnosis

3. If the claim is consequent upon an accident, please state the date and give full details of the accident. If you were involved in a road accident, please also provide registration numbers of the vehicles, name of third party's Insurer and the Police station where the accident was reported.

4. If there is any other insurance covering this illness or injury, please give all relevant details.

5. Is the treatment in connection with this illness or injury now completed? ☐ Yes ☐ No

6. If NO, do you intend submitting additional claim(s) for this illness or injury? ☐ Yes ☐ No

4. DETAILS OF DOCUMENTS INCLUDED

ALL documents must be Originals where possible.
If any document is missing or unreadable, the claim will be rejected.
YOU must make sure that the doctors, other therapists and pharmacists write clearly.

IN-PATIENTS

1. All documentation, investigations, treatments and a Medical Report about your admission.

OUT-PATIENTS

1. Doctors receipt(s)/report stating the diagnosis CLEARLY. Writing must be readable.
2. Doctors prescription(s).
3. Pharmacy receipts. Typed or CLEARLY written.
4. Doctors request letter for ALL tests done.
5. Doctors referral letters for physiotherapy or other therapies.
6. Breakdown of costs of all blood tests and other investigations.
7. Optical: Optician's prescription for new lenses, replacement or else.
8. Dental: Detail of procedure(s) done INCLUDING detail of tooth or teeth repaired.
9. Please list any other relevant documents below.

Please find attached ☐ bills amounting to SCR ☐ being claimed for above treatment.

I/we declare the above particulars are true and correct and undertake to give every assistance within my/our power to deal with this claim.

I hereby authorise my general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Sacos Insurance Group or their appointed representatives. I/we understand and accept that in case there is any doubt about this claim, Sacos Insurance Group reserves the right to have the claimant/patient cross examined by another medical practitioner of its choice.

Date | Policyholder's signature | Claimant's signature

SAC178-0419-V1

For office use by Sacos's Medical Officer