MS LIFE
A Member of the OLD MUTUAL Group

Hospital Cash Plan
Claim Form

Please fax the completed claim form and ALL required supporting documents to 086 676 2565 or email them to info@mslife.co.za

MS Life Service Centre Details

Telephone number:	086 000 2156
Fax number:	086 676 2565
E-mail:	info@mslife.co.za
Servicing hours:	08h00 – 16h30

IMPORTANT NOTES:
The policyholder must notify the insurer of a claim within six (6) months after the date of discharge from hospital. If this is not done then the insurer will not consider or pay the claim.

Your claim cannot be processed without supporting documentation. Please ensure that you attach the following documents (marked with the policy number) to this claim form:

- Certified ID of the policyholder
- If the person hospitised / claimant is not the policyholder (as applicable):
  - Certified ID of the person hospitalized / claimant
  - If a child, a certified copy of their birth certificate or adoption order (if applicable) and, if a full time student over 21, a letter from their institution
  - If the spouse, certified proof of spousal relationship e.g. certificate
- Letter or invoice from the hospital advising dates of admission & discharge
- Proof of account (bank statement/payslip/cancelled cheque) into which the claim is to be paid

This claim form must be stamped and signed by a doctor, together with copies of clinical notes of the patient and health card. Any fee charged to have this form completed, will be borne by the claimant.

1. POLICYHOLDER AND CLAIMANT'S DETAILS

Policy number ____________

Policyholder's name ____________

Claimant's relation to policyholder (please tick the appropriate box) Self ☐ Spouse ☐ Child ☐

If the claimant is not the policyholder, please provide the claimant's details:

Claimant's surname ____________

Claimant's first name(s) ____________

Claimant's ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Date of birth D D M M Y Y Y Y

Postal address ____________

____________ Code ____________

Telephone Code ______ No. ____________ Email address ____________

Fax Code ______ No. ____________ Cellphone number ____________

2. PATIENT'S DETAILS

Name and surname of patient hospitalised ____________

Date of birth of patient D D M M Y Y Y Y Relation to policyholder Self ☐ Spouse ☐ Child ☐

Is a claim being made in respect of a dependent child of the insured who at the time of the insured event was over 21 years of age? Yes ☐ No ☐

If so, is such person attending a school, college, or university? Yes ☐ No ☐

If yes, please attach proof of registration and state:

Name of institution ____________ Telephone number ____________

Is attendance full time, part time, correspondence or other? ____________

If not studying, is the dependent child over 21 years of age permanently mentally or physically disabled? Yes ☐ No ☐

3. DETAILS OF HOSPITLISATION

Name of hospital ____________ Telephone ____________

Ward name/number ____________ Patient's hospital file no ____________

Hospitilisation date — Admitted D D M M Y Y Y Y — Discharged D D M M Y Y Y Y

Reason for hospitalisation — Accident or injury ☐ Illness or disease ☐ Pregnancy, childbirth, miscarriage, abortion or complications there from ☐

Primary diagnosis

If accident or injury — Date of accident or injury D D M M Y Y Y Y — Nature of accident or injury

If illness or disease — On what date did he / she become aware of the complaint, illness or disease D D M M Y Y Y Y

Did he / she have any treatment for this disease / illness in the last 12 months? Yes ☐ No ☐

If yes, please provide date/s

If hospitilisation was due to pregnancy, childbirth, miscarriage, abortion or complications there from, please provide details

Was hospitalisation connected in any way to any of the following:

- Mental disease or disorder — Yes ☐ No ☐
- Use of alcohol — Yes ☐ No ☐
- The influence of any drug not administered on the advice of a doctor — Yes ☐ No ☐
- Injury or illness caused through self-infliction — Yes ☐ No ☐

5. PAYMENT INSTRUCTIONS

If my claim is admitted, please pay the benefit by electronic transfer into my bank account, details as follows:

Name of bank — Cheque ☐ Transmission ☐ Savings ☐

Name of branch — Branch code

Account number

6. DECLARATION BY CLAIMANT

I, the undersigned claimant hereby declare that the particulars contained herein, are true in every respect and made without reservation. I further irrevocably authorise any doctor or any person who has attended to me, or any other hospital or other institution that has medical information about me, to disclose such information to MS Life Assurance Company Limited, and agree that this authority shall remain in force after my death. Where the patient referred to in section 2 of this form is not me, I warrant that such patient has consented to the disclosure of medical information about him or her for the purposes of assessing this claim, and that he or she has expressly authorised me to give such consent on his or her behalf on this form.

Signed at — on this — day of — 20

Name — Name of patient

Signature of claimant

7. DECLARATION BY MEDICAL ATTENDANT

I hereby certify that the person hospitalised, as named in this form, was suffering from the injuries/illnesses referred to in this form and I know of no circumstances, other than the aforementioned, which might affect the assessment of the claim, if any, in respect of the person insured.

Signed at — on this — day of — 20

Name of medical attendant — Qualifications

Address

Telephone number Code — No. — Fax Code — No.

Signature of medical attendent

FOR OFFICE USE ONLY

Claimed by hand ....

Claimed by post ....

Date of commencement ....

HOSPITAL STAMP