CHUBB

Contact us for more information:

T 0860 223 252 F 011 783 0812 myclaim@chubb.com

Claim form

Hospitalisation & Medical Expense

Please write in black ink and use block capital letters.

- · Please return the completed claim form together with any enclosures to your insurance broker or to Chubb at the address shown
- The completion and/or submission of this claim form to us does not constitute an admission of your claim by Chubb Insurance Limited South Africa

Please ensure:

- You fully complete every question contained in this claim form
- That you attach a copy of your ID document
- That you attach a copy of the relevant hospital account / statement
- ☐ You fully complete every question **before** your doctor completes his statement
- Ensure that the hospital verification section is completed
- ☐ Your attending doctor fully completes the statement

Personal details – To be completed by the policy holder

Name of Policy:

Certificate/Policy Number:

Title: Full Name of Insured Person:

Date of Birth:

ID No.

Physical Address:

Tel. No (Home):

Tel. No (Business):

Fax No:

Cell Phone No:

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Email:

Details of illness

State the	date when the patient became awa	are of the illness:	Date first consulted t	he Doctor:					
Title:	Full Name of Patient:								
Relations	hip to policy holder:			ID No:					
Patient O	ccupation:	Height:		Weight:					
State the	full details and nature of the illnes	ss:		Who is the patient's usual medical practitioner?					
	lisation: (Please state full details)							
a) Name (of hospital/clinic:								
b) Admitt Date:	red Time:		c) Discharged Date:	Time:					
Has the p	Has the patient suffered this condition before?								
Details o	of the accident								
Please giv	ve exact date and time of the accid	ent:							
Date:		Time:		Am/Pm:					
Title:	Full Name of Injured Person:			ID No:					
Where di	d the accident occur?		How did the accident	t occur?					
Full detai	ls of injuries sustained:								

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Have you previously claimed u this or a similar policy?	ınder	Yes	No	If Yes, please give	details:				
Medical expenses									
Is the claimant a member of a Medical Aid/Scheme?		Yes	No						
Name and contact details of M	edical Aid/Scheme:			Scheme Name:					
				Membership Nun	ber:				
Hospital verification form	L								
This form is to be completed by an authorised member of the hospital administration staff and serves to verify the dates and times that the patient was admitted and discharged from your hospital.									
Full Name of Patient:				ID No:					
Admission:				Discharge:					
Date:	Time:			Date:	Time:				
Diagnosis:									
ICU									
Admission: Date:	Time:			Discharge: Date:	Time:				
Diagnosis:									
Authorised Signature of Hospital Administration Staff:			Date:						
Full Name of Administrator:									
Place Hospital Stamp Here:									

Authorisation

Please note that this claim form will not be accepted if this declaration has not been signed by the claimant or authorised person.										
I every respect complete, correct and true.	hereby warrant that the information given in this claim form is in ry respect complete, correct and true.									
I authorise any medical practitioner, hospital require relating to my medical history and the force at all times, and that a photo-copy or fay Insurance Limited may request additional inf requested herein, on completion and submiss	e injury/illness to which x for this declaration sha formation from any med	the claim relates. I agree that this conse Il be accepted as original. I agree and ac lical practitioner, hospital or any other p	ent shall remain ir cept that Chubb person not specific							
Signed by the claimant or his/her legal repres	sentative on this	day of	20							
Signature										
Doctor's statement										
This section must be fully completed by the presponsibility of the insured person.	atient's usual medical at	tendant – any fee for completion of this	section is the							
Title Patients Full Name and Surname:										
Date of Birth:	Height:	Weight:								
Full details of the illness/injury:	F	Final diagnosis:								
When did the patient first recieve medical att injury/illness:	ention for									
Has the patient ever suffered with this or any	similar condition before	e the present episode?	Yes	No						

If Yes, please give details including dates of treatments and consultations:

Please give name and address of consulting doctor:

Period of Hospitalisation: (Please state full details)

Type of hospital/ward:

Admitted: Date:

Time:

Is there any other infromation you feel is relevant?

Signed:

Date:

Please use validation stamp or complete in block capitals:

Name of Doctor/Consultant in charge:

Discharged: Date:

Time:

Print Name:

Tel. No:



ACE has acquired Chubb, creating a global insurance leader operating under the renowned Chubb name. Chubb Insurance South Africa Limited (Reg. No. 1973/008933/06) is an authorised Financial Services Provider (FSP No. 27176), Ground Floor, The Bridle, Hunts End Office Park, 38 Wierda Road West, Wierda Valley, Sandton, 2196.