Claim for The One Medical Plan/ The Hospital Policy

Please return the completed form to: **Policy claims**

Postal address PO Box 1, Sanlamhof 7532
E-mail address onemedicalplan@sanlam.co.za
Telephone number (021) 916-3457
Fax number (021) 947-6035

Plan number(s) _____

Important

- This form must be signed by the principal assured or his/her proxy and mailed or faxed to Sanlam Life Insurance Ltd. ("Sanlam Life").
- The claim form must be completed in full, stating the doctor's particulars, addresses, telephone numbers and fax number.
- The operation report must be completed in full by a surgeon.
- If you claim for emergency transport, an emergency transport account must be provided.
- Should more than one member of a family claim at the same time, a separate claim form in respect of each must be submitted.
- Copies of the hospital, surgeon's and anaesthetist's accounts related to the claim must be attached.
- According to the policy stipulations a claim must be submitted within three months of discharge from hospital.

Particulars of principal assured

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Rev ☐ Dr. ☐ Prof. ☐ Adv. ☐ Judge ☐

First name(s) and surname _____

Postal address _____ Postal code _____

Contact numbers: Telephone (home) ( ) _____ Fax (home) ( ) _____

Telephone (work) ( ) _____ Fax (work) ( ) _____

Cell phone _____

E-mail address _____

Particulars of patient *(life insured for whom is claimed for)*

Surname _____

Full name _____

Date of birth / / *(dd/mm/ccyy)*

Relationship to principal assured (e.g. self/spouse/child) _____

Particulars regarding Aids

- the patient for whom the claim is submitted been tested for HIV infection/AIDS now or in the past? Yes ☐ No ☐

If so, please state the relevant particulars

Name of doctor	Address of doctor	Result	Date dd / mm / ccyy
			/ /
			/ /
			/ /
			/ /

Plan number(s) _____

Nature of claim and details of consultations

- State the initials, surname, address and telephone number of your
  - Present family doctor _____

    Telephone number ( ) _____ Fax number ( ) _____
- Since which date have you been consulting your present family doctor? / / *(dd/mm/ccyy)*
  - Previous family doctor _____

    Telephone number ( ) _____ Fax number ( ) _____
- Since which date have you been consulting your previous family doctor? / / *(dd/mm/ccyy)*
- What illness, injury or impairment gave rise to this claim?

  _____
- On what date did the patient first become aware of the condition? / / *(dd/mm/ccyy)*
- On what date did the patient first consult a doctor for this condition? / / *(dd/mm/ccyy)*
- What are the initials, surname, address, telephone number and fax number of this doctor?

  _____

  Telephone number ( ) _____ Fax number ( ) _____
- Please provide the following information regarding all other doctors/specialists consulted with regard to the cause of this claim:

Initials and surname	Address	Telephone number	Fax number	Consultation dd / mm / ccyy
		( )	( )	/ /
		( )	( )	/ /
		( )	( )	/ /
		( )	( )	/ /

Details of hospitalisation

Period of hospitalisation *(please complete the table in full)*

Name of hospital	Patient number	Admission date dd / mm / ccyy	Discharge date dd / mm / ccyy	Time
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

- Has the patient claimed for the condition before? Yes ☐ No ☐ If so, when? _____

Plannommer _____

Details of hospitalisation *(continue)*

- During the period of hospitalisation, was the patient in:
  - An intensive unit? Yes ☐ No ☐
  - A high care unit? Yes ☐ No ☐

  Important

  If the answer to any of the above is "Yes", we require the detailed account from the hospital

  If so, state period(s) in unit:

Type of unit (Intensive care and/or High care)	Admission date dd / mm / ccyy	Discharge date dd / mm / ccyy	Time
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

- Did the patient receive radiotherapy or chemotherapy for a malignant condition? Yes ☐ No ☐

  If so, the annexures, *The One Medical Plan: Radiotherapy* and *The One Medical Plan: Chemotherapy* must be completed by the attending oncologist

Motor vehicle accident

- Was the patient's hospitalisation the result of a motor vehicle accident? Yes ☐ No ☐

  If so, please state the following in respect of the accident:

  Date of accident ____/____/____ *(dd/mm/ccyy)*

  Time of accident _____

  Police station where accident was reported _____

  SAPD/Namibia reference number _____

Important

If the patient answered No to questions regarding hospitalisation in an intensive unit, or he/she received radiotherapy or chemotherapy for a malignant condition or was hospitalised due to a motor vechile accident and was hospitalised for fewer than 4 days, he/she does not qualify for a claim in respect of the Daily Hospital Benefit (DHB).

Operations/Other medical procedures

- Has the patient undergone an operation/other medical procedures? Yes ☐ No ☐
- If so, please state in full the nature of the operation/medical procedures:

Name of hospital	Operation/medical procedure	Admission date dd / mm / ccyy	Discharge date dd / mm / ccyy
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

Plan number(s) _____

Operations/Other medical procedures *(continue)*

- When did the patient consult a medical doctor regarding the above-mentioned problem for the first time? ___/___/_____ *(dd/mm/ccyy)*
- Is your policy the One Medical Plan policy of Sanlam Life? Yes ☐ No ☐

  If so, please complete the annexure for *One Medical Plan: Operations Report* must please be completed by the doctor who carried out the operation or procedure.

Sports injuries

- Was/Is the patient's injury or emergency medical condition a result of participation in sports activities? Yes ☐ No ☐

  If so, please state the following:

  Type of sport practised

  _____

  Extent and nature of emergency medical condition or sports injury

  _____

  Date of emergency medical condition or sports injury ___/___/_____ *(dd/mm/ccyy)*

- If the patient underwent an operation or other medical procedure as a result of the emergency condition or sport injury, please statethe following:

  Date of operation ___/___/_____ *(dd/mm/ccyy)* Medical procedure _____

Emergency transportation

- Did the patient make use of emergency transportation Yes ☐ No ☐

  If so, please state the following:

  Dates of emergency transport *(dd/mm/ccyy)* ___/___/_____ ___/___/_____ ___/___/_____

- What type of emergency transportation was used?

  _____

- What are the initials, surname, address, telephone number and fax number of the doctor who recommended the emergency transportation?

  _____

Correspondence and payment particulars

Sanlam Life Insurance Ltd ("Sanlam Life") prefers to make all payments, if any, directly into your bank account. Kindly let us have your banking details. Cheques will be posted at your own risk. Sanlam Life is not responsible or liable for lost or stolen cheques.

Please fill in the following in respect of the bank account into which your cheque must be deposited:

Name of account holder _____

Name of bank _____

Name of branch _____

Account number _____

Branch code _____

Type of account Cheque ☐ Savings ☐ Transmission ☐ Other ☐ _____ *(Specify)*

Plan number(s) _____

Proxy and/or payment to a third party

If you would prefer your claim/payment to be handled/received by another person/institution, please provide us with the details below:

I, (insured owner) first names and surname: _____

Hereby authorise the person indicated below to handle the claim/receive the payment on my behalf and I indemnify Sanlam Life against any and all claims in respect of, and in connection with, the payment by Sanlam of the amount(s) concerned to this third party. (delete where not applicable)

Initials and surname of the person that could handle the claim on my behalf: _____

Address _____ Postal code _____

Initials and surname of the person that could receive the payment on my behalf: _____

Name of bank _____ Name of branch _____

Account number _____ Branch code _____

Account holder _____

Type of account Cheque ☐ Savings ☐ Transmission ☐ Other ☐ _____ *(Specify)*

Signature of insured owner _____

Date ____/____/_____ *(dd/mm/ccyy)*

Declaration by principal assured/authorised nominee

- I declare that the particulars of this claim and the supporting accounts are correct.
- I give my irrevocable permission for any medical practitioner, medical specialist, hospital, nursing institution or medical authority to provide Sanlam Life Insurance Ltd ("Sanlam Life") with any information Sanlam Life may require regarding the state of health of the patient. I certify that I am authorised to give permission on behalf of the patient.
- In addition, I irrevocably authorise Sanlam Life to share that information, and any information contained in that proposal or in any related policy, with other assurers, whether directly or by a database used by or for assurers as a group, at any time (even after my death) and in such a detailed, summarised or codified form as decided by Sanlam Life or the operators of the database from time to time.

Initials and surname of principal assured/authorised nominee _____

Signature of principal assured/authorised nominee _____

Date ____/____/_____ *(dd/mm/ccyy)* Place _____

The One Medical Plan: Radiotherapy

Important
Must be completed by the attending oncologist
The assured will be responsible for the payment of this account

Plan number(s) _____

Initials and surname of patient _____

Date of birth (dd/mm/ccyy) _____

Initials and surname of doctor _____

Doctor's telephone number _____

Diagnosis _____

Was the patient treated as an out-patient or as an in-patient?

_____

If as an in-patient, please supply us with the following

Admission date(s) *(dd/mm/ccyy)* ___/___/___ ___/___/___ ___/___/___

Discharge date(s) *(dd/mm/ccyy)* ___/___/___ ___/___/___ ___/___/___

Specific dates on which treatment was administered:

	Nature of consultation (e.g. planning, simulation or X-ray treatment)	**Nature of therapy** (e.g. protons, isotopes, protons or radioactive implantation)	**Date** dd / mm / ccyy
1			/ /
2			/ /
3			/ /
4			/ /
5			/ /
6			/ /
7			/ /
8			/ /
9			/ /
10			/ /
11			/ /
12			/ /
13			/ /
14			/ /
15			/ /

Signature of oncologist _____ Qualifications _____

Date ___/___/___ *(dd/mm/ccyy)* Place _____

The One Medical Plan:Chemotherapy

Important
Must be completed by the attending oncologist
The assured will be responsible for the payment of this account

Plan number(s) _____

Initials and surname of patient _____

Date of birth (dd/mm/ccyy) _____

Initials and surname of doctor _____

Doctor's telephone number _____

Diagnosis _____

Was the patient treated as an out-patient or as an in-patient?

_____

If as an in-patient, please supply us with the following

Admission date(s) *(dd/mm/ccyy)* ___/___/___ ___/___/___ ___/___/___

Discharge date(s) *(dd/mm/ccyy)* ___/___/___ ___/___/___ ___/___/___

Specific dates on which treatment was administered:

	Name of medication	**Method of administration** (e.g. intravenous, intramuscular, subcutaneous or oral)	**Date** dd / mm / ccyy
1			/ /
2			/ /
3			/ /
4			/ /
5			/ /
6			/ /
7			/ /
8			/ /
9			/ /
10			/ /
11			/ /
12			/ /
13			/ /
14			/ /
15			/ /

Signature of oncologist _____ Qualifications _____

Date ___/___/___ *(dd/mm/ccyy)* Place _____

The One Medical Plan: Operation Report

Important
(Must be completed by the attending surgeon.)
The assured will be responsible for the payment of this account
If a complete operation report is not available, the completion of this annexure is essential.

Plan number(s) _____

Initials and surname of patient _____

Date of birth (dd/mm/ccyy) _____

Initials and surname of surgeon _____

Practice number _____

Particulars of operation _____

Date of operation ___/___/_____ *(dd/mm/ccyy)*

Procedure carried out _____

_____

_____

Duration of operation _____

Pre-operative diagnosis _____

Date of diagnosis ___/___/_____ *(dd/mm/ccyy)*

Final diagnosis (if it differs) _____

_____

(Please provide us with a histological report if available.)

Rate code for main procedure carried out (according to MASA guide for fees) _____

Description of additional procedures carried out (if applicable)

_____

_____

_____

Rate code for additional procedure carried out (according to MASA guide for fees) _____

Indication(s) for operation

_____

_____

_____

Short description of operation (main procedure)

_____

_____

_____

_____

_____

_____

_____

Signature of surgeon _____ Qualifications _____

Date ___/___/_____ *(dd/mm/ccyy)* Place _____