Sanlam

Life Insurance

MEDICAL REFUND CLAIM FORM

DATE: ____

EMPLOYER: ____

PRINCIPAL MEMBER NAME: ____

PRINCIPAL MEMBER NUMBER: ____

CLAIMANT'S MEMBER NUMBER: _______________________ PHONE NUMBER: _________________

EMAIL ADDRESS: ____

BANK DETAILS

ACCOUNT NAME: ____

BANK NAME: ___________________________________ BRANCH: ___________________________

ACCOUNT NUMBER: ____

<u>**Reason for refund request.** ***(Please give a detail of the circumstances that led to this claim)***</u>

____

____

____

____

____

____

Principal Member signature: ___________________________ Date: ___________________________

HR signature and official stamp: ____

This form should be accompanied with original copies of clinical/ doctor's notes and payment receipts.