Sanlam Life Insurance

# Hospital Cash Benefit Claim Form

1. **Please attach hospital invoice receipt or an original, stamped certificate from the hospital reflecting dates hospitalized, reason for hospitalization, patient's file number and type of ward.**
2. **Please attach copies of claimant's ID and ID of the person hospitalized, or if a child, a birth certificate or record.**

## Personal information

Surname of policy holder: _____ First names: _____

Policy number: _____ Company/paypoint name: _____

Residential address: _____

Postal address: _____

Telephone number: ☐☐☐☐☐☐☐☐☐☐ Occupation: _____

Full names of patient hospitalised: _____

Relationship to policy holder: _____ Date of birth: D D M M Y Y Y Y

## Details of hospitalisation

Hopspital to which admitted: _____

Name of ward: _____ Patient's hospital file number: _____

Reason for hospitalisation: _____

Date admitted: D D M M Y Y Y Y Date discharged: D D M M Y Y Y Y

Was hospitalisation a result of accident or injury?: Yes ☐ No ☐ Date of accident/injury: D D M M Y Y Y Y

Nature of injury: _____

Was patient confined to I.C.U?: Yes ☐ No ☐ If yes, date confined to I.C.U from D D M M Y Y Y Y to D D M M Y Y Y Y

When did he/she become aware of the complaint, illness or disease?: _____

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

If yes, please give details: _____

## Additional information

Was hospitalization connected in any way to any of the following?

- Mental disease or disorder, excessive use of alcohol, the influence of any drug not administered on the advice of a doctor, injury or illness caused through intentional self-inflicted and sexually transmitted disease, any violation of the criminal law, the result of any insurrection, civil commotion, war, participation in any speed contests, cosmetic surgery including obesity, active participation in mountaineering, horse riding, hunting, power boat racing, motor racing, etc.

  Yes ☐ No ☐ If yes, please give details: _____

- In case of a female, was hospitalization due to pregnancy, childbirth, miscarriage, abortion or any complications there from?

  Yes ☐ No ☐ If yes, please give details: _____

- Was the illness or injury sustained while the person assured was resident overseas? Yes ☐ No ☐



**Sanlam Life Insurance Zambia Limited**
Zenera House, Corner Lagos and Lubuto Road
P.O Box 31991, Lusaka, Zambia

## Declaration by policy owner

I, the undersigned, hereby declare that the above particulars are true in every respect and made without reservation. I further irrevocably authorize any doctor or any other person who has attended to me or my relatives, or any other hospital or other institution which has medical information about me or my relatives to disclose such information to Sanlam Life Issurance Company Zambia Ltd and agree that this authority shall remain in force after my death.

Signed at _____ Date: D D M M Y Y Y Y

**Signature of patient (if not policy owner)**

**Signature of policyholder**

## Declaration by medical officer

I, hereby certify that the person hospitalised, as named in the 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 injured.

Signed at _____ Date: D D M M Y Y Y Y

**Signature of medical attendant**

Name in block letters: _____

Qualifications: _____

Telephone number: _____ Fax number: _____

Address: _____

**Please place hospital stamp here**