



MEDICAL INSURANCE CLAIM FORM

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Claims@curaadmin.co.za

Administrators (Pty) Ltd
"an authorised financial services provider"
Reg No: 1997/017797/07 FSP No: 26848

INSTRUCTIONS:

Please ensure that the following documents are submitted with this form.

- Hospital / Doctor Account / Medical scheme statement, reflecting the date of service
- Proof of payment of co-payment
- Proof of bank account details - not older than 3 months

Cura Policy No:

Cura Product:

1. PRINCIPAL INSURED DETAILS: Please fill in your details below. Ensure that all fields are marked clearly and can be read easily.

Name(s):

Initials:

Surname:

ID Number:

Contact Number:

Cell No:

E-mail:

2. PATIENT DETAILS: The claim remittance report will be sent to the patient's email address, as provided.

Relationship to

Self:

Spouse:

Child:

Other:

Date of Service:

Principal Insured:

Name(s):

Initials:

Surname:

ID Number:

Contact No:

Cell No:

E-mail:

Medical Scheme:

Option:

Member

Name of Main
Member:

No:

3. BANKING DETAILS OF BENEFICIARY: No third party / credit card payments will be accepted.

Name of Account

Holder:

Name of Bank:

Branch:

Account Number:

Branch Code:

Type of Account:

Transmission Account:

Current Account:

Savings Account

Account Holders Signature: _____

Date: _____

4. ACKNOWLEDGEMENT AND DECLARATION:

I declare that the above particulars are true in every respect and I attach or will forward as soon as possible copies of all hospital, medical accounts and relevant medical aid statements. I hereby authorise any hospital, physician or other person who has attended to or examined me or my dependents, to furnish to Cura, or its authorised representative, any information with respect to any illness or injury, medical history, consultations or treatment and copies of all hospital or medical records. You hereby authorise and mandate us to obtain all necessary information from your Medical Scheme, including but not limited to biographical information, benefit and claim information, and medical information. A Photostat copy of this authorisation shall be considered as effective and valid as the original. I consent to Cura or any authorised 3rd party from obtaining and processing my (or my dependents) personal information and I understand why my /their personal information is required and the purpose it will be used. This consent and mandate will remain in force until withdrawn in writing. I acknowledge that I have the right to request from Cura, details of any of my personal information Cura holds on my behalf and details of how my personal information has been processed and to lodge a complaint with the Information Regulator. Except to the extent that we acted with gross negligence or fraudulent intent, you hereby indemnify us and undertake to hold us harmless against any loss, damage, legal liability, legal costs (including costs on an attorney and client scale) or expenses of whatever nature we may suffer or become liable for alleged to arise or arising from the consent and mandate you provided to us in accordance with this Agreement.

Signed at

on this

day of

20

Principal Insured Signature: _____

Patient Signature: _____

(If the patient is a minor, the form must be signed by the parent or guardian, who confirms that they are the competent and authorised person to sign on behalf of the minor).

In Case of Minor: Name of Competent and
Authorised Person:

Relationship to
Minor Patient:

Underwritten by:

Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)



CONSTANTIA

Insurance made personal