Administrators (Pty) Ltd
An authorised financial services provider – FSP: 26848

Claim Form

Call Centre: 086 155 3553
Fax: 086 681 3670
E-Mail: mail@curaadmin.net

1. Client Details:

Claim Number Office Use Only: ______

Surname		First Names	
ID Number		Cell	
Tel (W)		E-mail Address	
Medical Scheme		Member Number	
Option		Diagnosis	
Cura Policy Number		Cura Product	
Joining Date		Benefit Date	
Service Date		Duration of Hospitalization	

Waiting Period: None ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐

Patient		Date of Birth	

Relationship to Principal Insured: Self ☐ Spouse ☐ Child ☐

Reason for Claiming: Accident ☐ Illness ☐ Surgical ☐ Childbirth ☐ Natural Death ☐ Unnatural Death ☐

2. Bank Details of Beneficiary:

Account Holder's Name			
Bank Name		Branch Name	
Account Number		Branch Code	

Account Type: Current Account ☐ Transmission Account ☐ Savings Account ☐

Account Holder Signature ______________________

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 and service provider accounts and relevant medical aid statements. I hereby authorise any hospital, physician or other person who has attended to or examined me or my dependants, to furnish to the 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. A Photostat copy of this authorisation shall be considered as effective and valid as the original.

Principal Insured Signature ______________________ Date ______________________

Brokerage [ ] Broker Representative [ ]

No deductions will be allowed from a credit card account.

Please Attach:
A copy of the Premium Payer's ID document;
Proof of bank details (Top section of bank statement / Cancelled cheque / Letter from bank)