AFFINITY HEALTH

Hospital Claim Form 2024

This form is required for the Insurer to assess a possible claim. Completion of this form by an Insured Person does not in any way limit liability. Only once we have received a fully completed claim form will we be able to assess the incident being claimed for. Any cost incurred in the completion of this form will be the responsibility of the Insured Person.

Section 1: Personal Details

Name of Policy holder:		ID Number:	
Membership Number:			
Full Name of Patient:			
Date of Birth of Patient:			
Occupation:			
Residential Address:			
Postal Address:			
Date of Incident:			
Give a detailed description of how the incident happened:			

In the event of a Motor Vehicle Accident, please attach copies of the Police Accident Report, Road Accident Report and Witness Statement (if any)

Section 2: Banking Details for Refunds (if any):

Bank:		Code:	
Branch:		Type:	
Account Holder:		Account No:	

Section 3: Certificate from usual/attending medical practitioner (To be completed by the Doctor)

Full Name of Patient:	
Description of Incident:	
Please state the cause and nature of Disability/inactivity:	
Does this present ailment relate in any way to previous injuries or pre-existing conditions? If yes, please elaborate:	

Section 4: Please gove details of any other attending Doctor

Name:			
Telephone Number:			
Address:			
		Code:	
Please give any other details which you feel may be relevant:			

Signature of Doctor: | Doctors Full Name:

Date:

Authorisations to be completed by the Insured person or their legal representative:
I hereby authorise any hospital, physician or other person who has treated me to furnish the Insurer, or their representatives, with all the information regarding any injury, sickness, medical history, consultations, precsriptions or treatment, including copies of all hospital or medical records. I agree that a photo/fax copy of this authorisation shall be accepted as the original.

Name and Surname:		ID/Passport:	
Date:		Place:	
Signature of the individual granting authorisation:		Capacity:	

The original first page of the Hospital Bill is to be submitted with this claim form. In respect of Accident claims, ll in-hospital bills are to be submitted as and when they become available.

Signature by the Policyholder on this ____ day of ____ 20 ____ at ____

Signature: ____ Name: ____

Section 5: Authority to make Payment

Dear Sir/Madam

AUTHORITY TO MAKE PAYMENT - AFFINITY HEALTH

AFFINITY HEALTH MEMBERSHIP NUMBER: ____

I hereby confirm that I ____ as the policyholder of the Affinity Health policy hereby authorise Affinity Life Limited, on behalf of the insurer, to pay the stated benefits due to me in terms of the policy to the service provider concerned. I acknowledge that any outstanding amounts owed to the service provider over and above the benefit payable by Affinity Health will be for my account.

I record that this is a power of attorney authorising Affinity Life Limited to make payment of my funds as directed by me and is a cession of any benefits in terms of the Affinity Health Policy.

SIGNATURE OF POLICY HOLDER ____

SIGNED AT ____ ON THE ____ DAY OF ____ 20 ____

Claim Form may be forwarded to us via Email: hospitalclaims@affinityhealth.co.za or Fax: 086 607 9419