Healthcare

A division of A.W. Jack & Associates (Pty) Ltd

KNIGHTS INSURANCE BROKERS Hospiplan Claim Form

This form is required in order for the Underwriters to assess a possible claim.
Completion of this form by the Insured or 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 or the Insured Person.

Section 1: General

Policy Number:
Full Name of Insured Person:
Occupation:
Date of Admission:
Name of Hospital:
Tel No of Hospital:
Name of Usual General Practitioner:
Tel No of Usual GP:
Name of Specialist:
Tel No of Specialist:

Section 2: Hospitalisation Claim

Date of Discharge:
Invoices to be listed here:
1:
2:
3:
4:
5:
6:
7:
8:
9:
10:
11:
12:
13:
14:

Authorisation to be completed by the Insured Person or the legal representative: I hereby authorise any hospital, physician or other person who has treated me to furnish the Underwriters or their representatives with all the information with regard to any injury, sickness, medical history, consultations, prescriptions or treatment including copies of all my hospital or medical records. I agree that a photo/fax copy of this authorisation shall be accepted as the original. Signature of the individual granting authorisation:	
Capacity:	
Date:	Place:

Section 3: Certificate from Usual Medical Practitioner

Full name of patient:
What is the definitive diagnosis?
When did signs and symptoms first occur?
What date was the condition first diagnosed?
Does this present condition relate in any way to a previous injury or pre-existing condition? If yes, please elaborate:
How long have you been the patient’s medical practitioner?
Please give any other details which you feel may be relevant:
Doctor’s Signature:
Doctor’s Name:
Date:
Telephone Number:
Please give details of any other attending Doctor/Specialist:
Name:
Telephone Number:

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