CHUBB®

Contact us for more information:

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Claim form

Hospitalisation & Medical Expense

Please write in black ink and use block capital letters.

- Please return the completed claim form together with any enclosures to your insurance broker or to Chubb at the address shown
- The completion and/or submission of this claim form to us does not constitute an admission of your claim by Chubb Insurance Limited South Africa

Please ensure:

You fully complete every question contained in this claim form
- ☐ That you attach a copy of your ID document
- ☐ That you attach a copy of the relevant hospital account / statement
- ☐ You fully complete every question **before** your doctor completes his statement
- ☐ Ensure that the hospital verification section is completed
- ☐ Your attending doctor fully completes the statement

Personal details – To be completed by the policy holder

Name of Policy:

Certificate/Policy Number:

Title:

Miss

Full Name of Insured Person:

Date of Birth:

ID No.

Tel. No (Business):

Physical Address:

Tel. No (Home):

Fax No:

Cell Phone No:

Email:

Details of illness

State the date when the patient became aware of the illness:

Date first consulted the Doctor:

Title: Miss

Full Name of Patient:

Relationship to policy holder:

ID No:

Patient Occupation:

Height:

Weight:

State the full details and nature of the illness:

Who is the patient's usual medical practitioner?

Hospitalisation: (Please state full details)

a) Name of hospital/clinic:

b) Admitted
Date:

Time:

c) Discharged
Date:

Time:

Has the patient suffered this condition before?

Details of the accident

Please give exact date and time of the accident:

Date:

Time:

Am/Pm:

Title: Miss

Full Name of Injured Person:

ID No:

Where did the accident occur?

How did the accident occur?

Full details of injuries sustained:

Have you previously claimed under this or a similar policy? ☐ Yes ☐ No

If Yes, please give details:

Medical expenses

Is the claimant a member of a Medical Aid/Scheme? ☐ Yes ☐ No

Name and contact details of Medical Aid/Scheme:

Scheme Name:

Membership Number:

Hospital verification form

This form is to be completed by an authorised member of the hospital administration staff and serves to verify the dates and times that the patient was admitted and discharged from your hospital.

Full Name of Patient:

ID No:

Admission:
Date:

Time:

Discharge:
Date:

Time:

Diagnosis:

ICU

Admission:
Date:

Time:

Discharge:
Date:

Time:

Diagnosis:

Authorised Signature of Hospital Administration Staff:

Date:

Full Name of Administrator:

Place Hospital Stamp Here:

Authorisation

Please note that this claim form will not be accepted if this declaration has not been signed by the claimant or authorised person.

I _____ hereby warrant that the information given in this claim form is in every respect complete, correct and true.

I authorise any medical practitioner, hospital or other person to provide Chubb Insurance Limited with any information they require relating to my medical history and the injury/illness to which the claim relates. I agree that this consent shall remain in force at all times, and that a photo-copy or fax for this declaration shall be accepted as original. I agree and accept that Chubb Insurance Limited may request additional information from any medical practitioner, hospital or any other person not specifically requested herein, on completion and submission of this form and any other documentation as submitted by me.

Signed by the claimant or his/her legal representative on this _____ day of _____ 20 _____

Signature _____

Doctor's statement

This section must be fully completed by the patient's usual medical attendant – any fee for completion of this section is the responsibility of the insured person.

Title: Miss

Patients Full Name and Surname:

Date of Birth:

Height:

Weight:

Full details of the illness/injury:

Final diagnosis:

When did the patient first recieve medical attention for injury/illness:

Has the patient ever suffered with this or any similar condition before the present episode? ☐ Yes ☐ No

If Yes, please give details including dates of treatments and consultations:

Please give name and address of consulting doctor:

Period of Hospitalisation: (Please state full details)

Type of hospital/ward:

Name of Doctor/Consultant in charge:

Admitted:
Date:

Time:

Discharged:
Date:

Time:

Is there any other infromation you feel is relevant?

Signed:

Print Name:

Date:

Tel. No:

Please use validation stamp or complete in block capitals:

Chubb. Insured.℠