Universal House, 15 Tambach Road,
Sunninghill Park, Sandton
PO Box 1411, Rivonia 2128
Telephone: +27 11 208 1000
Facsimile: 086 532 6595
E-mail: cover@universal.co.za
www.universal.co.za

INDIVIDUAL HEALTH COVER CLAIM FORM

Claims should be submitted in writing by no later than one hundred and eighty (180) days from the admission date into hospital (i.e. complete the claim form as soon as possible). Claim forms are to be returned to:

Ambledown Risk and Underwriting Managers (Pty) Ltd, P O Box 1862, Cramerview, 2060; or
Faxed to 011 463 1665; or
Emailed to claims@ambledown.co.za

PRINCIPAL INSURED MEMBER DETAILS

Surname: ______ Initials: ______

ID no.: ______ Policy/Member no.: ______

CONTACT DETAILS

Postal address: ______

______

Postal Code: ______ Fax: ______

Telephone no.: ______ E-mail address: ______

Cellphone no.: ______ Work no.: ______

Employer: ______ Contact no.: (   ) ______

FAMILY DOCTOR (GP) DETAILS

Name: ______ Telephone no.: (   ) ______

PATIENT DETAILS

First name(s): ______

Surname: ______

ID no.: ______ Male ☐ Female ☐

Relationship to the principal member: Self ☐ Spouse ☐ Child ☐ Other ☐

Medical aid & plan option: ______ M/Aid no.: ______

Is the claim in respect of a dependent child over 18 years of age? Yes ☐ No ☐

If Yes, please attach details of the school, college or university attended by the patient and/or proof that the child is totally dependent on the principal member.

Reason for hospitalisation: ______

When did the patient first receive treatment and/or advice in the above regard? ______

DETAILS OF HOSPITAL ADMISSIONS:

Was hospitalisation a result of an accident/injury? Yes ☐ No ☐

Hospital name	Practice no.	Ward type	Date admitted	Date discharged

PROVIDERS/DOCTORS DETAILS:

Name	Practice no.	Date of service	Telephone no.

PRODUCT DETAILS

Gap Cover: [ ] Gap Cover Plus: [ ]

PAYMENT INSTRUCTIONS

Benefits to be paid into my bank account by electronic fund transfer, details below:

Account holders name:

Account no.:

Bank:

Branch name: Branch code:

Account type: Current Saving Transmission (No credit card accounts accepted)

SIGNATURE OF ACCOUNT HOLDER
(PRINCIPAL INSURED MEMBER)

NAME OF ACCOUNT HOLDER
(PRINCIPAL INSURED MEMBER)

The company will not be liable for the loss of funds due to the provision of incorrect bank details by the member.

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 and medical accounts and relevant medical aid statements. I hereby authorise any hospital, physician or other person who has attended or examined me or my dependants to furnish to the company or its authorised representative any information with respect to any illness or injury medical history consultation prescriptions 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.

SIGNATURE OF THE PRINCIPAL INSURED MEMBER

NAME AND SURNAME OF THE PRINCIPAL INSURED MEMBER

Date signed: D D M M Y Y Y Y

BROKER DETAILS

Broker name:

BEFORE ANY CLAIM CAN BE SETTLED, COPIES OF THE FOLLOWING DOCUMENTATION RELATING TO THIS PARTICULAR CLAIM ARE REQUIRED:

1. Hospital accounts
2. Doctors’ accounts
3. Medical aid statement

(Failure to provide all applicable documentation to this claim form will cause undue delay in the processing thereof.)