

DETAILS OF CLAIM - PLEASE COMPLETE THE FOLLOWING IN FULL

DIAGNOSIS

HOSPITAL NAME

DATE OF HOSPITALISATION FROM TO

NAME OF ADMITTING DOCTOR

DOCTOR'S PRACTICE NUMBER TEL NO.

NAME OF FAMILY DOCTOR TEL NO.

Date of service	Service provider	Amount charged	Paid by medical aid	Shortfall
YYYYMMDD	<input type="text"/>	R <input type="text"/>	R <input type="text"/>	R <input type="text"/>
YYYYMMDD	<input type="text"/>	R <input type="text"/>	R <input type="text"/>	R <input type="text"/>
YYYYMMDD	<input type="text"/>	R <input type="text"/>	R <input type="text"/>	R <input type="text"/>
YYYYMMDD	<input type="text"/>	R <input type="text"/>	R <input type="text"/>	R <input type="text"/>

PAYMENT INSTRUCTIONS

IMPORTANT NOTE: PLEASE READ POINT 5 UNDER DECLARATIONS

BENEFITS WILL ONLY BE PAID BY ELECTRONIC FUND TRANSFER INTO THE BANK ACCOUNT AS DETAILED BELOW

ACCOUNT HOLDERS NAME

ACCOUNT NUMBER (11 Digits Maximum)

BANK

BRANCH NAME BRANCH CODE

ACCOUNT TYPE CURRENT TRANSMISSION SAVINGS (No Credit Card Accounts Accepted)

Signature of Account Holder

Signature of Principal (If different from Account Holder)

DECLARATION

- (1) I/We hereby declare that the person mentioned under claimant details is nominated under the abovementioned policy that all the particulars given are true and complete, and that the hospitalisation was not wholly or partly, directly or indirectly, caused by the contingencies mentioned in both the General and Specific exceptions as well as any addendum attached to the policy in question,

In particular, I'm aware that this claim does not fall into one of the following 2 exceptions:

- No benefits shall be payable for an insured event for which the insured member received treatment or advice twelve (12) months prior to becoming an insured member (pregnancy and/or childbirth-related hospitalization included). This exclusion only applies to the first twelve (12) months of an insured member's cover.**
- A 3-month general waiting period will apply from date of inception for all procedures other than due to an accident.**

- (2) I/We further declare that the above statements are true and that I/we have withheld no material information and that I/we undertake to furnish any documentation which may be required by the insurer/ administrator.
- (3) I/We expressly waive all provisions of law, custom or professional etiquette forbidding any physician or other person who attended or examined the claimant, or any institution in which the claimant received treatment, to disclose any knowledge or information which was thereby acquired and agree that this authority shall remain in force until cancelled in writing.
- (4) I/We authorise all such persons or agencies to furnish any information in their possession to the insurer/ administrator or to Linksave on request.
- (5) **Linksave reserves the right to negotiate settlement with the relevant service providers on behalf of the insured. Where Linksave settles directly with a provider, no payment will be made to the insured. Where possible, we request that the insured submits the claim form to Linksave before settling with a provider in order to allow us to negotiate a favourable settlement amount. Should the service provider be unwilling to accept payment on our terms, then payment will be made in the customary manner to the policy holder.**

Signature - PRINCIPAL MEMBER

Date

Signature - PATIENT (if different from PRINCIPAL MEMBER)

Date