RENASA
INSURANCE COMPANY LIMITED

HEALTH CLAIM FORM

LINKSAVE
Closing the gap

LINKSAVE MUST BE NOTIFIED OF ANY CLAIM IN WRITING WITHIN 6 MONTHS FROM DATE OF TREATMENT OF SUCH INCIDENT.
NOTE: A SEPARATE FORM IS REQUIRED FOR PREMIUM WAIVER OR RETRENCHMENT BENEFIT CLAIMS

PLEASE ATTACH THE FOLLOWING DOCUMENTS APPLICABLE TO THE DATE OF INCIDENT:

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

THE FOLLOWING REQUIREMENTS ARE **COMPULSORY:**

- ☐ HOSPITAL ACCOUNT (FIRST FOUR PAGES ONLY)
- ☐ DOCTORS ACCOUNTS
- ☐ MEDICAL AID CLAIMS STATEMENT

PLEASE RETURN TO:

Linksave (Pty) Ltd
Tel: 031 564 8920
Fax: 086 459 5549
PO Box 201533, DurbanNorth, 4016
Email: claims@linksave.co.za

PERSONAL PARTICULARS

PRINCIPAL MEMBER

LINKSAVE POLICY NO.

SURNAME TITLE

FIRST NAMES

ID NUMBER DATE OF BIRTH

MEDICAL AID

MEDICAL AID OPTION

MEDICAL AID MEMBER NO.

CONTACT DETAILS: Linksave will correspond with you via e-mail & cellphone only. Kindly ensure that these details are completed in full

POSTAL ADDRESS	PHYSICAL ADDRESS (IF DIFFERENT)
POSTAL CODE	POSTAL CODE

TELEPHONE NUMBERS

HOME WORK CELL

EMAIL ADDRESS

PARTICULARS OF PATIENT

SURNAME ☐ MALE ☐ FEMALE

FIRST NAMES

DATE OF BIRTH

ID NUMBER

RELATIONSHIP TO MEMBER

☐ SELF ☐ SPOUSE ☐ CHILD

IMPORTANT NOTE: Unmarried Child Dependants over the Age of 21 and up to the Age of 27 must be a Dependant on the Principal Insureds Medical Scheme

PLEASE COMPLETE ON PAGE 2 FULL AND COMPREHENSIVE DETAILS PERTAINING TO THE ABOVE CLAIM

14 March 2017
Linksave (Pty) Ltd is a registered financial services provider,
FSP no 45594

DETAILS OF CLAIM - PLEASE COMPLETE THE FOLLOWING IN FULL

DIAGNOSIS

HOSPITAL NAME

DATE OF HOSPITALISATION FROM DATE TO DATE

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
Y Y Y Y M M D D		R	R	R
Y Y Y Y M M D D		R	R	R
Y Y Y Y M M D D		R	R	R
Y Y Y Y M M D D		R	R	R

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:

1. **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.**
2. **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 possesion to 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

14 March 2017