MEDICAL EMERGENCY AND RELATED EXPENSES CLAIM FORM

Date sent to us _____ Claim reference number (if known) _____

Please answer all relevant questions on the claim form. Leaving items blank, using ticks, dashes and n/a may result in us returning the claim form and/or asking further questions, thus delaying the processing of your claim.

Hollard Travel Insurance is underwritten by The Hollard Insurance Company Limited (Hollard), a registered short-term insurer and an authorised financial services provider, and managed by Oojah Travel Protection (Pty) Ltd.

Please send your completed claim form and all supporting documentation to: Oojah Travel Protection, Fax No: 0866 43 44 36 or claims@hollardti.co.za. For assistance you may contact them on 0861 OOJAHT or 0861 665 248.

CLAIMANT DETAILS

Title	Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other	Country of residence	
Surname		Nationality	
First name		Postal address	
Date of birth			
Home telephone		Postal code	
Work telephone		ID number	
Mobile telephone		Date of booking (trip)	
E-mail		Departure date	
Policy number		Return date	
Date policy purchased		Number in party	

Credit card number used to purchase tickets _____

Do you or anyone else claiming have any other insurance which may cover the claim, e.g. airline, medical aid, bank/credit card insurance YES ◯ NO ◯

If YES, please provide details below

Company name _____ Policy number _____

Have you or any person claiming under this policy made any previous claims on this type of insurance YES ◯ NO ◯

If YES, please provide details _____

DECLARATION and AUTHORITY

1. I/We hereby declare that all information, answers, and documentation given in connection with this claim are **true and correct** to the best of my/our knowledge and belief. I/We have not omitted any material information, which could affect the underwriter's judgement of the claim.
2. I/We understand that the information on this form will be passed to or used by us and our appointed claims handling agent, this includes underwriting, processing, handling claims and preventing fraud.
3. I/We **authorise any doctor, hospital or other organisation or person having any records or information concerning my medical history or treatment** to furnish such records of information as may be requested by us or our claims handling agent. I am also aware that such information/records are relevant in the evaluation of my claim and that non-submission could prejudice my claim. A photocopy of this authorisation shall be considered as effective and valid as the original.
4. I/We further declare that I am/We are aware that any **misrepresentation and/or non-disclosure** in respect of information provided herein shall render my/our claim null and void.
5. I/We declare that I/We have **read the policy wording**.

I have read and fully understand the declaration above (ALL persons claiming must sign)

Insured Person's Name and Surname	**Date of Birth**	**Signature**

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Documents You need to send to Us – SEND COPIES OF DOCUMENTS AND KEEP ORIGINAL DOCUMENTS FOR YOUR RECORDS

1. **Itinerary**: Original travel tickets for your booked itinerary (including tickets from/back to South Africa).
2. **Illness**: we require a 6 months medical history from your usual GP.
3. **Illness and/or Injury**: Detailed medical report including diagnosis from the treating medical practitioner abroad.
4. **Accident/injury**: incident report/police report.
5. All original invoices/receipts for expenses incurred.
6. If claim is submitted on behalf of a deceased insured, we will require certified copies of the death certificate. If the insured passed away due to illness rather than as a result of injury, we require a medical certificate to be completed by the deceased's usual GP.

Important: please number all receipts for expenses incurred and put the number in the column headed "Receipt No." when completing the Medical Expenses section below.

Please answer ALL questions – BLOCK CAPITALS PLEASE

Date injury/illness occurred _____ Country where injury/illness occurred _____

Full description of illness or injury and details of any third party involved, including **diagnosis**

Diagnosis _____

Description _____

_____

If you were an inpatient: Date of admission _____ Date of discharge _____

If your expenses exceeded R5 000 did you contact the medical emergency assistance company YES ◯ NO ◯

If YES, please complete the fields below, if NO please provide a written explanation as to why this was not done

_____

_____

Date of first call _____ Person spoke to and reference number _____

MEDICAL AND OTHER EXPENSES (Please list all expenses and continue on a separate sheet if necessary)

Receipt number	Date	Description of item	Bill from (provider/ doctor's name)	Amount	Currency	Paid Y/N	Office use

Total claimed (Rand) 0.00

Are you expecting to receive or are you going to submit any further accounts YES ◯ NO ◯

If YES, please provide details _____

_____

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ALL CLAIMS RELATING TO ILLNESS (including death)

To be completed by the person that is the cause of the claim's regular treating doctor.

Please note that this information will be treated as confidential and will only be used to assess the travel insurance claim. We hereby confirm that this information is pivotal to the claim as no authorisations for payment can be issued until this report has been inspected by our own independent medical advisor.

1. Name and surname (of the person that was the cause of the claim) _____
2. Date of departure _____
3. Regular doctor's name and surname _____
4. Doctor's PR number _____
5. Patient's medical aid number _____
6. Diagnosis (reason for the claim) _____
7. Date of diagnosis _____
8. Date of first consultation relating to the condition _____
9. In your opinion, does the diagnosis relate directly or indirectly to a pre-existing medical condition for which the patient received either treatment or advice YES ◯ NO ◯
10. List of chronic medications – prior to the date of departure

Condition	Date of diagnosis	Name of medication

11. List of prescribed medication – prior to date of departure (if different from chronic)

Condition	Date of diagnosis	Name of medication

12. Date and reason for last 5 consultations (prior to date of departure)

Date	Details

13. Date and details of most recent surgical procedures

Date	Details

_____ Medical practice stamp _____

Doctor's signature and date completed: _____

Important Notes:

A policy excess is applicable in respect of all outpatient claims. If you require us to make direct payment of the medical costs, you need to pay the policy excess before we can do so. Please contact us to arrange payment. If you have paid all costs, we will reimburse all valid claims less the excess amount. Please enclose receipts of payments made.