

Hospital Cash Plan Claim Form

Kindly answer all questions in full and attach supporting documentation as listed below. Please note the following:

- This form should be submitted after the patient, who is an Insured Person covered under the plan, has been discharged from hospital or after day 21 in hospital, for longer hospital stays.
- Section 1 – 6 must be completed by the claimant.
- Section 7 – 8 must be completed by the Medical Practitioner.

SUPPORTING DOCUMENTS FOR THIS CLAIM *(Please attach the following documents)*

- Certified copy of Policyholder's proof of identity
- Certified copy of the patient's proof of identity
- Proof of bank details for beneficiary
- Hospital Medical records / invoice

Liberty life reserves the right to call for additional documents where necessary in order to validate the claim

Policy number

POLICYHOLDER DETAILS

Surname

First names Gender M F

Identity number Date of birth D D - M M - Y Y Y Y

Telephone number Mobile number

Email address

Postal address Postal code

PATIENT DETAILS

Is the Life Assured Policyholder Spouse Child

Surname

First names Gender M F

Identity number Date of birth D D - M M - Y Y Y Y

CLAIM PAYMENT DETAILS

BANK DETAILS FOR CLAIM PAYMENTS THROUGH EFT

(Please attach confirmation of account details on the Bank's letterhead or cancelled cheque.)

Name of accountholder

Name of bank

Account number Branch name

Branch code Account type

CLAIM DETAILS

HOSPITAL DETAILS

Name of Hospital	<input type="text"/>																								
Hospital address	<input type="text"/>																								
Hospital telephone number	<input type="text"/>												Fax	<input type="text"/>											
Admitting Doctor	<input type="text"/>																								
Doctor's telephone number	<input type="text"/>												Fax	<input type="text"/>											
Primary reason for hospitalisation	<input type="text"/>																								
	<input type="text"/>																								
Admission date	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>										
Discharge date	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>										
Number of days in ICU, if applicable	<input type="text"/>																								
Hospitalisation is due to:	<input type="checkbox"/>	Disease/illness				<input type="checkbox"/>	Accident/injury/trauma																		

IF HOSPITALISATION IS DUE TO AN ACCIDENT

Date of accident	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>									
Place	<input type="text"/>																							
Provide details of how the accident occurred	<input type="text"/>																							
	<input type="text"/>																							
What injuries did you sustain?	<input type="text"/>																							
	<input type="text"/>																							
Was the accident reported to the police?	<input type="checkbox"/>	<input type="checkbox"/>																						
Name of police station	<input type="text"/>																							
Case number	<input type="text"/>																							

IF HOSPITALISATION IS DUE TO A DISEASE/ILLNESS

Nature and earliest symptoms of the condition	<input type="text"/>																								
	<input type="text"/>																								
Date of earliest symptoms of the condition	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>															
When did you first consult a medical doctor regarding the condition?	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Date diagnosis confirmed	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
Prescribed treatment you are currently taking/using	<input type="text"/>																								

MEDICAL PRACTITIONER'S DETAILS

Medical Practitioner's full name	<input type="text"/>																								
Postal address	<input type="text"/>																								
	<input type="text"/>																								
Physical address	<input type="text"/>																								
	<input type="text"/>																								
Telephone number	<input type="text"/>												Fax	<input type="text"/>											
Email address	<input type="text"/>																								

CLAIMANT'S DECLARATION

I, in my capacity as claimant, hereby certify that the above information submitted by me, is to the best of my belief and knowledge both true and correct. I further confirm that I have not withheld, concealed or misstated any information. I hereby authorize any Medical Practitioner or hospital to furnish Liberty or its appointed representatives with information relating to the patient's illness or injury. I authorize the Insurer to collect and share information. I accept that with this authorization I am limiting my right to privacy. However to assess the insurance risk, I irrevocably authorize the Insurer to obtain from any person, whom I hereby permit and request to give any information which the Insurer needs and share with other Insurers that information and any information in this application or any related source at any time a form approved by the Insurer or the Life Assurance Association of Namibia.

Claimant's name and surname

Claimant's signature Date - -

MEDICAL CERTIFICATE *This certificate is to be completed by the attending (treating) medical practitioner at the insured's expense*

Name of patient

Policy number

HOSPITALISATION DETAILS

Name of Hospital

Hospital address

Admission date - - Time

Discharge date - - Time

Primary diagnosis for admission

Date of first diagnosis - - Time

Number of days in ICU, if applicable

Additional diagnoses

PRIMARY REASON FOR ADMISSION

Acute disease/illness Chronic disease/illness Medical investigation Accident

Mental disorder Alcohol or drug use/dependence Treatment of infertility Obesity

Elective surgery Other (please specify)

IF HOSPITALISATION IS DUE TO AN ACCIDENT

Date of accident - - Time

What injuries did the patient sustain?

Please give details of specific procedures performed

Please give details of treatment prescribed and administered

ACKNOWLEDGEMENT BY ATTENDING DOCTOR

I certify that the above information is, to the best of my knowledge and belief, true and accurate, and that no information has been withheld, nor has any information regarding the circumstances been omitted.

Medical Practitioner's full name

Practice name Registration number

Doctor's telephone number Fax

Email address

Medical Practitioner's signature Date - -