ECONET LIFE (PRIVATE) LIMITED

ECOSURE HOSPITAL CASH BACK PLAN CLAIM FORM

Benefits shall be payable for every day spent in hospital from the fourth day of continuous hospitalization.

Claims must be notified within 30 days of hospital discharge. Econet Life reserves the right to call for additional documentation from time to time.

Terms, conditions and exclusions shall apply.

The following documents must be submitted to Econet Life: (Tick submitted documents)

- ☐ Patient card
- ☐ Hospital Statement
- ☐ Medical Aid Card used
- ☐ Receipts for all cash payments
- ☐ Letter of admission and discharge
- ☐ Discharge Summary
- ☐ Test Results
- ☐ Diagnosis letter
- ☐ Police Report (For Accident)
- ☐ Copy of ID of claimant

I HEREBY IRREVOCABLY AUTHORISE and request any Doctor or other person who may be in possession of, or hereafter acquire, any information concerning my health up to date hereof to disclose such information to Econet Life (Pvt) Ltd and I agree that, this authority and request shall remain in force after my death as well as prior thereto. Signed …….....

POLICYHOLDER DETAILS

Surname: _____First Names:_____

ID Number:_____D.O.B:_____

Phone Number:_____Address_____

PATIENT DETAILS

Patient/Dependent hospitalised:_____D.O.B:_____

(NB: Benefits for dependents are paid directly to the dependent)

Relationship to policy holder:_____Phone Number:_____

Date of Hospitalisation: _____Time of Hospitalisation:_____

Date of Discharge:_____Time of Discharge:_____

Reason for Hospitalisation: _____

_____

Name of Medical Aid:_____Medical Aid Number:_____

HOSPITAL AND DOCTOR DETAILS:

Name of Hospital:_____

Address of Hospital:_____

Telephone: _____

Name Of Admitting Doctor:_____AHFOZ Number:_____

Name Of Discharging Doctor:_____AHFOZ Number:_____

Have you ever suffered from the disease you were hospitalised with, if so, give dates:

_____.

Fraud warning: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals , for the purpose of misleading , information concerning any fact material thereto commits a fraudulent insurance act , which is a crime.

_____ _____ _____

Print claimants name Claimants signature Date

EcoSure Hospital Cashback

CERTIFICATE OF MEDICAL ATTENDANT
(TO BE FURNISHED AT THE PATIENT'S EXPENSE)

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PATIENT DETAILS

Name of patient

Reason for Hospitalisation; that is Diagnosis and Date of diagnosis

In Ward Treatment given

Known pre-Existing Condition and date of diagnosis/duration of Condition

1. Condition	Date of diagnosis
2. Condition	Date of diagnosis

Medical Questionnaire

1. Was the admission as a result of a known pre-existing condition? If yes, when was the initial diagnosis done?

2. Is the patient suffering from a chronic condition?

3. Was admission for the management of pain and or investigation of same?

Doctor's signature & Date…….. Qualifications……

DECLARATION

I hereby certify that the above-mentioned information and that the forgoing statements are correct.

Doctor's stamp