OLDMUTUAL

IN-PATIENT CLAIM FORM

Part I - TO BE COMPLETED BY PATIENT/MEMBER

Full name of patient: ______________________________

Member No. ______________________ Member Tel No. ______________________

ID Card No. ______________________ Date of Birth ______________________

Full name of member (if patient is a dependant) ______________________

Member's employer name ______________________

When did the present sickness start? ______________________

Have you suffered from this sickness in the past? ☐ Yes ☐ No

If yes, when did it start and how frequent is it? ______________________

Part II - TO BE COMPLETED BY ADMITTING/ATTENDING DOCTOR

Hospital Name ______________________

Date of Admission ______________________ Date Discharged ______________________

Attending Doctor's Name ______________________

Tel: ______________________ Email ______________________

Final Diagnosis ______________________

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Consultant Referred to ______________________ Specialty ______________________

Doctor's Signature ______________________

Declaration

I understand that any incorrect statement or the non-disclosure of any material information in this form may jeopardize my claim. I warrant that the answers in this form are true, correct and complete and I acknowledge that such answers are all material. I hereby authorize the hospital, medical or dental practitioners who have treated me or any of my dependants to disclose to the Company the records relating to such current or previous hospitalizations / medical treatment and to allow the Company to receive extracts from such records and undertake to assist in obtaining such information.

Member's Signature ______________________ Date ______________________

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