Day1 Health (Pty) Ltd – Medical Insurance
Exeter House, 54 Peter Place, Bryanston, Johannesburg
Tel: 0876 100 600 | Fax: 086 690 4818
www.day1health.co.za | admin@day1.co.za
P.O. Box. 782622, Sandton City
Johannesburg, Gauteng, 2146

HOSPITAL CLAIM FORM

This form is required in order for Insurers to assess a possible claim. Completion of this form by the Insured or an Insured Person does not in any way limit liability. Only once we have received a fully completed claim form will we be able to assess the incident being claimed for. Any cost incurred in the completion of this form will be the responsibility of the Principal Member or the Insured Person.

SECTION 1: GENERAL

Name of Principal Member:	
Membership Number:	
Full Name of Insured Person:	
Occupation:	
Date of Birth:	
Date of Incident:	
Time of Incident:	
Place of Incident:	
Please give a detailed description of how the Incident happened:	
Residential Address:	
Postal Address:	
Telephone (Home):	
Telephone (Office):	
BANKING DETAILS FOR REFUNDS IF ANY	
Account Holder:	
Bank:	
Account Number:	
Branch:	
Branch Code:	
Account Type:	

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SECTION 2: CERTIFICATE FROM USUAL / ATTENDING MEDICAL PRACTITIONER

Full name of patient:

Description of incident:

Please state cause and nature of disability / inactivity:

Does this present ailment relate in any way to previous injuries or pre-existing conditions? If yes, please elaborate:

Please give details of any other attending Doctor:

Name:

Telephone Number:

Address:

Please give any other details which you feel may be relevant:

Signature:

Full Names Doctor:

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Authorizations to be completed by the Beneficiary / legal representative. I hereby authorize any hospital, physician or other person who has treated me to furnish the Insurers or their representatives with all the information with regard to any injury, sickness, medical history, consultations, prescriptions or treatment including copies of all my hospital or medical records. I agree that a photo/fax copy of this authorization shall be accepted as the original.

Signature of the individual granting authorizations: _____

Capacity: _____

Date & Place: _____

Signed by the Beneficiary this _____ day of _____ 20_____at _____

SIGNATURE _____

PRINT NAME _____

Day1 Health (Pty) Ltd
PO Box 782622
Sandton City
2146

Claim Forms may be forwarded to us by email or fax
claimshospital@day1.co.za or 086 551 6456

All claim forms to be accompanied by full hospital account and all other relevant accounts.
Any accounts submitted after 120 days after date of service will be rejected as stale.

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AUTHORITY TO MAKE PAYMENT

Dear Sir/Madam

AUTHORITY TO MAKE PAYMENT – DAY 1 HEALTH CARE INSURANCE

DAY 1 HEALTH MEMBERSHIP NUMBER: _____

I hereby confirm that I (print name) _____ as the Principal Member and Insured person of the DAY1 Health Policy hereby authorise Insurance Outsourcing Managers (Pty) Ltd (IOM) on behalf of DAY1 Health Policy, to pay the stated benefits due to me in terms of the policy to the service provider concerned on the basis that any surplus funds, if applicable, will be paid to my account.

I acknowledge that any outstanding amounts owed to the service provider over and above the DAY1 Health Policy, will be for my account.

I record that this is a power of attorney authorising IOM to make payment of my funds as directed by me and is not a cession of any benefits in terms of the DAY1 Health Policy.

Yours faithfully

Print name _____

Signature _____
DAY 1 HEALTH MEMBER (sign & print full name)

Date _____

SEND COMPLETED FORM EMAIL claimshospital@day1.co.za **OR FAX** to **086 551 6456**