

All Care Product is underwritten by Sanlam Developing Markets Limited (Reg no. 1911/003818/06) a licensed Life Insurer and an authorised Financial Services Provider FSP 11230 and is administered by Groups Are Us (Pty) Ltd an authorised FSP 45735.

DETAILS OF THE MAIN MEMBER OR PRINCIPAL INSURED													
Name				Surname									
ID Number				Policy Number									
BANK DETAILS OF THE NOMINATED BENEFICIARY TO RECEIVE THE BENEFIT													
Account Holder Name				Bank									
Please provide your correct Bank Account Number						Branch code							
Type of Account		Cheque		Savings		Transmission		Other, specify					
DETAILS OF PERSON IN HOSPITAL													
Name				Surname									
ID Number				Medical Aid Name									
Cell No				Medical Aid Number									
Relationship to Main Member (e.g., spouse, child, or self)													
DETAILS OF HOSPITALISATION													
Reason for Hospitalisation (diagnosis)													
Date of Symptoms (yyyy/mm/dd)													
On what date did the patient first consult the doctor with these symptoms? (yyyy/mm/dd)													
Name of Hospital													
Type of Ward													
Patient Hospital File Number													
Admission Date (yyyy/mm/dd)				Discharge Date (yyyy/mm/dd)									
Referring Doctor Name													
Referring Doctor Address													
Give full details and dates of previous admission of the Life Assured to a hospital for a similar reason(s):													
Name Hospital		Type of Ward		Patient's Hospital File Number				Admission Date		Discharge Date		Diagnosis	
Other reasons for being admitted if not related to the above:													
During the period of hospitalisation was the patient in an Intensive Care Unit?										YES		NO	
Admission Date (yyyy/mm/dd)				Discharge Date (yyyy/mm/dd)									
In Theatre				YES		NO		Admission Date (yyyy/mm/dd)					
Was hospitalisation a result of an accident or injury?				YES		NO		Event date (yyyy/mm/dd)					
Nature of Injury													
Details of Event													
MEDICAL HISTORY													
Family Doctor's Name													

Telephone Number		Address		
Since when has the Life Assured consulted the present family doctor				
Provide the following information regarding all the other Doctors or Specialists consulted relating to the claim				
Name of Doctor/Hospital	Telephone Number	Diagnosis/Treatment	Tests Concluded	Consultation Date (yyyy/mm/dd)
Please provide the following details regarding any other illness or injury where a doctor was consulted in the last 5 years				
Name of Doctor/Hospital	Telephone Number	Diagnosis/Treatment	Tests Concluded	Consultation Date (yyyy/mm/dd)

DECLARATION OF POLICY HOLDER OR LIFE ASSURED

Policyholder (if Policyholder/Life Assured or a minor is the patient).

I declare that the details of this claim and the supporting accounts are correct. I give my permission for any medical practitioner, medical specialist, hospital, nursing institution or medical authority to give **Sanlam Developing Markets Limited** any information they may need regarding the state of my health or that of the minor. In addition, I allow **Sanlam Developing Markets Limited** to share that information and any information contained in this claim form or any related policy, with other assurers whether used directly or by a database use for assurers as a group, at any time (even after my death) and in such a detailed, summarised, or codified form as decided **Sanlam Developing Markets Limited** or the operators of this database from time to time. I also allow **Sanlam Developing Markets Limited** to share it more specifically with other Life Offices directly, or through Association for Saving and Investments South Africa (ASISA) for the purpose of underwriting and / or claims assessment.

Member's Signature	Date (yyyy / mm / dd)

DOCUMENTS TO BE SUBMITTED TO SANLAM

DOCUMENTS TO BE ATTACHED ✓ Tick what is relevant to the claim and to be submitted	Main Member	Spouse	Common Law Spouse	Child	Student	Stillborn	Extended family
	SANLAM Claim Form						
Certified copy of ID document: Main Member							
Birth Certificate to confirm natural children							
Amended Birth Certificate to confirm legally adopted children							
Affidavit to confirm non legally adopted children							
Marriage Certificate							
Affidavit in the case of a common law marriage							

In case of children older than max age as specified in policy:

Registration at tertiary institution stating full time student and dependent							
Doctors' confirmation for a mentally or physically disabled child							

In case of hospitalisation, hospital accounts must indicate the minimum information below.

Main member name & ID, patient name and ID, admission date, discharged date, ICD 10 codes and Nappi and tariffs codes	
Motivation letter explaining why it was clinically necessary or any other information deemed necessary to complete the claim assessment	
Surgeon's medical report	
Discharge summary report	