



Admed Claim Form

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For office use only

CLAIM NO:

NB - YOUR CLAIM CANNOT BE PROCESSED WITHOUT THE FOLLOWING SUPPORTING DOCUMENTATION :-

1. PROOF OF HOSPITALISATION
(THE FIRST TWO (2) PAGES OF THE HOSPITAL ACCOUNT OR THE MEDICAL AID STATEMENT REFLECTING PAYMENT TO THE HOSPITAL)

AND

2. DETAILED DOCTORS ACCOUNTS

3. PERSONAL ACCIDENT CLAIMS – Applicable to the Admed Principal Member only
- Important to view the Claims Guide for a list of relevant documentation required

PLEASE ENSURE THAT ALL REQUESTED DOCUMENTATION IS ATTACHED TO AVOID CLAIMS SETTLEMENT DELAYS

Admed Products:

AdmedGap
AdmedPulse

A: NAME OF EMPLOYER :

DIVISION :

B. MEMBER'S PARTICULARS:

Full Name of Member:

I.D. Number of Member:

Date of Birth:

Postal address of Member:

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Tel : (Work)

Tel: (Home)

Tel : (Cell)

Email Address:

Fax :

Joining date: Employer

Employee number :

Joining date: Medical Aid Fund

Medical Aid Fund:

Medical Aid Fund Number:

C: PATIENT'S PARTICULARS:

Full Name of Patient:

Relation to Member (Please tick the appropriate box):

Self	Spouse	Child
Other		

Date of Birth:

F: PERSONAL ACCIDENT CLAM (FOR THE ADMED PRINCIPAL MEMBER ONLY):

Give full details of the injuries sustained by the claimant	
Name of the Attending Doctor	
Practice Number	
Telephone Number	
Address	
Please state the period during which the claimant was totally disabled from attending to his/her usual occupation	From:
	To:
Please state the date upon which he/she resumed light duties	
Has any permanent disablement resulted from this accident, if yes, please give details	

G: PERSONAL ACCIDENT CLAM (FOR THE ADMED PRINCIPAL MEMBER ONLY) – EMPLOYERS CERTIFICATE:

This certificate is to be completed by the Salaries or Human Resources Department

Full Name of Claimant	
Is the Claimant a full time permanent employee?	
Please confirm that the disability and dates of absence from work stated in this claim for are correct	
State fully the nature of the claimant's occupation and daily duties	

In the event of an IOD please confirm and provide the following :

Was this IOD reported?	
Do you have a COID Claims Number?	

Please note that the following documents must be submitted as soon as possible:

1. Employer's report of an Accident (WCL1)
2. First Medical Report (WCL4)
3. Progress or Final Medical Report (WCL5)
4. Resumption Report (WCL6)

Declaration by Employer

I hereby warrant the truth of all particulars on this form in every respect and declare that all conditions of this insurance have been complied with

Signature and Capacity	
Date	
Company Stamp	

H: PERSONAL ACCIDENT CLAM (FOR ADMED PRINCIAL MEMBER ONLY) – MEDICAL CERTIFICATE:

This certificate must be completed by the attending doctor consulted

Full Name of Patient	
When were you first consulted by the claimant in connection with his/her injuries?	
Are you still in attendance?	
What was the cause of the accident so far as known?	
What injuries were sustained?	
Please state the exact cause and nature of the disability and any important factors connected therewith	
Does the present disability relate in any way to previous injuries or pre-existing conditions or illnesses?	
If yes, please explain	
Is the patient now or was he/she at the time of the accident subject to or suffering from any illness or disease irrespective of the accident for which the benefit is claimed?	
If so, state the nature of it, and to what extent the recovery of the patient may be effected thereby	
Is the patient temporarily or permanently disabled from attending to any portion of his/her usual business or occupation?	
If yes, please explain	
Please state any information not already mentioned which is relevant to the assessment of any permanent disability arising from the accident	
If the patient has fully recovered, please state the date of recovery	

Declaration by Medical Practitioner

I hereby certify that the above statements are true in every respect

Name and Practice Number	
Qualifications	
Signature and Date	
Address	
Telephone Number	

I: ADMED PRINCIPAL MEMBERS BANK ACCOUNT DETAILS: PLEASE NOTE THAT NO PAYMENTS TO 3rd PARTIES WILL BE PROCESSED

Following acceptance of my claim,

a. pay the benefit into my bank account

a. Name in which account is registered: _____

b. Type of account: _____
(Current /Savings/Transmission)

c. Name of Bank / Building Society: _____

d. Branch Name: _____

e. Branch Code: _____

f. Account Number: _____

b. mail the benefit cheque to:

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.....
.....

J. DECLARATION BY PRINCIPAL MEMBER:

I declare that the above particulars are true in every respect and I attach copies of all hospital and other medical accounts.

I hereby authorise any hospital, physician or other person who has attended to me, or examined me or my dependants, to furnish to Guardrisk or its authorised representative any information with respect to any illness or injury, medical history consultation, prescriptions or treatment and copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and as valid as the original.

Principal Member's Signature:

Date: