Claim form:

Declaration for Hospital Cash/Major Medical/ Lifestyle Protector/Dread Disease benefit

To be completed by claimant

METROPOLITAN
Together we can

This certificate is required to consider a claim under policy _____ issued by

Metropolitan on the life of: _____

Please tick applicable benefit:

☐ Hospital Cash Benefit ☐ Major Medical Benefit ☐ Dread Disease ☐ Lifestyle Protector

1 Personal Particulars

1. (a) Name of the person in respect of whom claim is made: _____

(b) Date of birth: _____

(c) Relationship to policyholder: _____

(d) Name and address of usual medical attendant: _____

_____

(e) Name of medical aid scheme and membership number, if applicable: _____

(f) Name, address and telephone number of employer: _____

_____

2 Nature of claim

2. (a) Please list the ailment/injury suffered as well as medical procedure or treatment for which this claim is made:

_____

_____

_____

(b) Name of medical practitioner and date of first consultation in connection with this condition:

_____

_____

(c) Name the physician/specialist seen with this condition and date of first consultation:

_____

(d) Date of and diagnosis by physician/specialist:

_____

_____

_____

(If the diagnosis is in respect of a condition representing full-blown Aids, state on what basis Aids was diagnosed.)

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3. Particulars of doctors

3. (a) Please give details of doctors (including specialists) who have been consulted in connection with this condition:

Name	Address	Date(s) consulted

4. Particulars of hospitals

4. (a) Please give details of hospitals where treatment was received

Name of hospital	Patient no.	Date of admission	Date of discharge

(b) If insured was ever confined to an intensive care unit, please state: From _____ to _____

(c) If the insured was hospitalised for a serious accident, injury or acute life-threatening condition, state if emergency transport was used: _____

(If emergency transport was used and policy has an emergency transport benefit, attach emergency transport invoice to this form)

(d) If the insured was hospitalised due to a motor vehicle accident state the following

(i) Date of accident: _____ (ii) Time of accident _____

(iii) Place of accident: _____

(iv) Police station where accident was reported: _____

(v) Case number: _____

(e) Please supply short description of the accident: _____

I hereby declare under oath that the replies to the questions and the statements made above, are true and correct in every respect.

SIGNED at _____ this _____ day of _____ 20 _____

Claimant signature

Address: _____

Telephone: _____

NOTE: TO SPEED UP THE FINALISATION OF THE CLAIM YOU ARE REQUESTED TO FURNISH US WITH A COPY OF THE FULL SPECIFIED HOSPITAL ACCOUNT.