MEDICAL PROTECTION CLAIM FORM

CLIENT NO.________________

AGENCY NO.________________

NAME:	
ADDRESS:	
POLICY NO:	DUE DATE:

ALL QUESTIONS MUST BE ANSWERED BEFORE A CLAIM CAN BE PROCESSED

ALL CLAIMS MUST BE FULLY DOCUMENTED, I.E. ALL RELEVANT, CERTIFICATES, RECEIPTS AND PROOF OF ACTUAL COSTS MUST BE SUBMITTED WITH THIS FORM.

1. WERE ANY OF THE CHARGES INCURRED DUE TO INJURY OR SICKNESS ARISING OUT OF THE PATIENT'S EMPLOYMENT YES/NO IF "YES" GIVE DETAILS.	
2. ARE YOU ENTITLED TO RECEIVE ANY OF THESE EXPENSES FROM ANY OTHER (1) MEDICAL INSURANCE POLICY (2) WORKERS COMPENSATION POLICY (3) AMBULANCE FUND (4) COMMON LAW CLAIM? (B) WILL YOU BE MAKING A CLAIM?	
3. WERE ANY OF THESE CHARGES INCURRED AS A RESULT OF ALCOHOLISM, DRUG ADDICTION, MENTAL ILLNESS, PSYCHOTIC OR PHYCHONEUROTIC DISORDERS? YES/NO IF "YES" IS/WAS PATIENT HOSPITALISED?	
4. DURING THE PAST 12 MONTHS PERIOD PRIOR TO YOUR PARTICIPATION IN THIS MEDICAL PROTECTION POLICY DID YOU RECEIVE TREATMENT OF ANY SORT, WHICH IS THE SUBJECT MATTER OF YOUR CLAIM FOR MEDICAL OR REPATRIATION EXPENSES?	DETAILS:
5. HAS ANY ACCIDENT, SICKNESS, MEDICAL AND LIFE INSURER EVER DECLINED A PROPOSAL FROM YOU OR CANCELLED OR DECLINED TO RENEW YOUR POLICY OR REQUIRED IT TO BE ENDORSED, OR REQUIRED AN INCREASED PREMIUM TO BE PAID?	DETAILS:

DECLARATION

I DECLARE THAT THE PARTICULARS GIVEN ON THIS CLAIM FORM TO BE TRUE AND CORRECT IN EVERY RESPECT AND THAT THE COMPLETION OF THIS FORM AND THE SIGNING OF IT BY ME IS A CLAIM AGAINST THE COMPANY. I FURTHER ACKNOWLEDGE THAT ANY UNTRUTH, MISREPRESENTATION OR SUPPRESSION BY OR ON BEHALF OF ME IN ANY DECLARATION OR STATEMENT IN SUPPORT OF THE CLAIM MADE HEREIN MAKES THE POLICY UNDER WHICH THIS CLAIM IS MADE VOID AND THE PREMIUM FORFEITABLE.

....INSURED'S SIGNATURE - DATE

Patients Name	Name of Doctor/Hospital	Condition for which treatment is sought	Date of Treatment	Amount