



## Section 2

For your protection and to ensure speedy payment of your claim, payment will be made by electronic transfer into the bank account supplied. If the consent form in Section 3 is completed, the medical scheme contributions, up to the maximum benefit limit, will be paid directly to the medical scheme. If the maximum benefit limit is lower than the actual medical aid contribution, the benefit will be paid directly to the beneficiary. It will be the beneficiary's responsibility to pay the medical scheme.

**NB: It is important to give the correct account number and name of the account holder to be credited. Liberty will not be held responsible for delays or any other loss due to incorrect details being provided.**

### 2.1 Medical scheme plan information

Current calendar year \_\_\_\_\_ Current claim year \_\_\_\_\_  
Current medical scheme name \_\_\_\_\_ Current medical scheme plan \_\_\_\_\_  
Membership of current medical scheme plan: From date \_\_\_\_\_  
Current main member contribution  R  \_\_\_\_\_ p.m.  
Previous medical scheme name\* \_\_\_\_\_ Previous medical scheme plan\* \_\_\_\_\_  
Previous main member contribution\*  R  \_\_\_\_\_ p.m.  
Membership of previous medical scheme plan\*: From date \_\_\_\_\_ To date \_\_\_\_\_  
 One parent deceased OR either or both parents disabled/impaired  Both parents deceased

\* Only if different to current and when transferring between medical schemes or medical scheme plans while in claim.

### 2.2 Medical scheme contact details

Address \_\_\_\_\_ Postal code \_\_\_\_\_  
Contact numbers: Work \_\_\_\_\_ Fax \_\_\_\_\_  
Email address \_\_\_\_\_  
Contact person \_\_\_\_\_

### 2.3 Medical scheme banking details for the payment of medical scheme contributions

**Only applicable if Liberty will facilitate the medical scheme contribution payment on behalf of the beneficiary**

Account holder's name \_\_\_\_\_  
Bank name \_\_\_\_\_ Account number \_\_\_\_\_  
Branch name \_\_\_\_\_ Branch code \_\_\_\_\_  
Account type:  Cheque  Savings  Transmission

## Section 3

### 3.1 Consent for Liberty to pay benefit(s) directly to the medical scheme

I, \_\_\_\_\_ (full name and surname),

authorise Liberty to pay the medical scheme contributions payable under this benefit, directly to the medical scheme stated above.

I authorise Liberty to contact my medical scheme in order to obtain the latest medical scheme membership certificates after the medical scheme's annual review have been completed. This is done in order for the contribution payments to be updated and to verify dependants under the medical scheme plan.

Signed at \_\_\_\_\_ on \_\_\_\_\_

\_\_\_\_\_  
Signature of beneficiary/  
medical scheme plan main member

\_\_\_\_\_  
Signature of authorised representative/  
curator/guardian if beneficiary is a minor

## Section 4

### 4.1 Declaration

I, \_\_\_\_\_ (full name and surname),

declare that all the above information provided is true to the best of my knowledge and that no material fact has been intentionally withheld from Liberty.

Signed at \_\_\_\_\_ on \_\_\_\_\_

\_\_\_\_\_  
Signature of beneficiary/  
medical scheme plan main member

\_\_\_\_\_  
Signature of authorised representative/  
curator/guardian if beneficiary is a minor

**NB: PLEASE CHECK THAT THE FULL CLAIM FORM IS COMPLETED AND THAT ALL REQUIREMENTS ARE SUBMITTED TOGETHER WITH THIS FORM TO ENABLE THE SMOOTH PROCESSING OF THE CLAIM.**

