Liberty Group Limited (registration no. 1957/002788/06) - an Insurer and an Authorised Financial Services Provider (no. 2409)
Liberty Centre, 1 Ameshoff Street, Braamfontein, Johannesburg, 2001
PO Box 10499, Johannesburg, 2000
Contact Centre number: 0860 456 789 / +27 (0) 11 558 4871
E-mail address: info@liberty.co.za

MEDICAL LIFESTYLE CLAIM FORM IN RESPECT OF:

We are required to share, collect and process your Personal Information (PI). Your PI is collected and processed by our staff, representatives or sub-contractors and we make every effort to protect and secure your PI. You are entitled at any time to request access to the information Liberty has collected, processed and shared.

Please tick applicable product type:

☐ **MEDICAL LIFESTYLE** ☐ **MEDICAL LIFESTYLE PLUS**

We would like to process your medical claim accurately and as quickly as possible. To enable us to meet this objective, we request that you ensure all applicable detail is correctly completed on this form and all requirements are forwarded to:

Liberty
Claims Management

Alternatively, forms may be hand delivered to :

Liberty Centre
Claims Department
1 Ameshoff Street
Braamfontein
Johannesburg

To facilitate the completion of the claim form, Section 1 lists all benefits that can be claimed against each product type and identifies the relevant sections to be completed for the benefit type being claimed against. Each section specifies additional requirements as applicable.

IMPORTANT FACTS TO BE TAKEN NOTE OF:

- Take careful note of the requirements as you complete the relevant sections and remember to attach these together with your claim form where applicable.
- For Medical Lifestyle Plus claims in respect of Crisis Care Benefits, please send all related documentation to Netcare 911 or Europ Assist, as applicable.
- It is important that you include the diagnosis and ICD-10 code (Diagnosis code) for all benefits being claimed. Please consult your attending doctor for this information.
- Medical Lifestyle members, please submit your claim documentation as per your booklet instructions.
- **Where the claim is to be paid into a bank account other than the bank account from which the premiums are collected, please ensure that proof of the bank account is submitted with this claim – (Please refer Section 1.3. – Payment Details for full explanation**).
- **Should there be a charge from a medical doctor for the completion of the Attending Doctor's Statement, you are solely responsible for the full settlement of this.**
- **Should this be a childbirth claim, please contact your Financial Adviser to obtain a complete quote to add the newborn**

We trust that your medical claim process will be a customer friendly experience and ask you to please contact your Financial Adviser or our Call Centre on 0860 456 789/+27 (0)11 558 4871 should you require any assistance.

Please note that in the event of any modification or variation of this standard form Liberty will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

SECTION 1 *(compulsory for all claims)*

1.1 GENERAL DETAILS

Name of Life Assured: _____ Policy no: 5 2 _____

Name of patient: _____ Patient's date of birth: _____
(dd/mm/yyyy)

If you were previously covered under another Medical Lifestyle policy, please supply the policy number: 5 2 _____

Please note that correspondence will be sent to the last address on record. If your address has changed recently, please ensure that we have the correct details:

New address: _____ Postal Code: _____

Contact telephone numbers (h) _____ (w) _____ Fax: _____

Email: _____ Cell: _____

NB: IF YOUR SURNAME HAS CHANGED PLEASE SUPPLY A COPY OF YOUR MARRIAGE CERTIFICATE AND NEW ID DOCUMENT

1.2 PAYMENT DETAILS

For your protection and to ensure speedy payment, payment of your claim will be made by electronic transfer into the premium paying bank account of the Principal Life Assured. **Should bank details differ to the account details on record, please provide proof of account i.e. a copy of a cancelled cheque OR copy of current bank statement on a bank letterhead OR a copy of a printout from the bank with a bank stamp and a certified copy of the Principal Life Assured's ID document or Passport.**

Name of account holder: _____

Name of bank: _____ Branch: _____

Branch code: _____ Account type: _____

Account number: _____

I, _____ (the Policyholder), herewith request and authorise Liberty to pay any monies due in terms of this claim into the bank account as stated above.

Signed at _____ Date _____ _____
Signature of Life Assured

NB: IT IS EXTREMELY IMPORTANT TO GIVE THE CORRECT ACCOUNT NUMBER AND NAME OF THE ACCOUNT HOLDER TO BE CREDITED. LIBERTY IS NOT RESPONSIBLE FOR DELAYS OR LOSSES DUE TO INCORRECT DETAILS BEING PROVIDED.

1.3 FINANCIAL ADVISER DETAILS

Contact person for this claim: _____ Branch: _____

Contact telephone no.: _____ Fax no.: _____

Email: _____ Cell: _____

SECTION 2 What are you Claiming for?

2.1 GENERAL CLAIM DETAILS

MEDICAL LIFESTYLE BENEFITS	✓ Benefit	Sections to be completed					MEDICAL LIFESTYLE PLUS BENEFITS	✓ Benefit	Sections to be completed			
Specific Chronic Conditions	☐	1	2.3	3	4		Chronic	☐	1	2.3	3	4
Childbirth	☐	1	2.2.	2.6	3	4	Accelerated	☐	1	2.4	3	4
Chemotherapy/Radiotherapy	☐	1	3	4			Recovery (Post-Hospitalisation)	☐	1	2	3	4
Hospitalisation/Procedure	☐	1	2.4	2.6	3	4	Hospitalisation	☐	1	2	3	4
Emergency Transport	☐	1	3				Crisis care	☐	1			

Crisis Care – Netcare 911 / Europ Assist –For Medical Lifestyle PLUS only

- Submit Accounts directly to Europ Assist
- No Medical Lifestyle Claim form required
- Completed TIC/Europe Assist Claim Form
- Copy of airline tickets
- Original invoices and receipts regarding Medical Cover
- Attending Doctor's Report
- Local General Practitioner's contact details

NB: Remember to provide copies of accounts for hospital, surgeon, anaesthetist and diagnostic tests and any other costs incurred during the period of hospitalisation.

2.2 CHILDBIRTH CLAIM

If your claim is in respect of CHILDBIRTH and your children need to be added to the policy, please provide the following details:

Newborn Baby – Name in full	Date of Birth	Gender(M/F)	Description of present state of health

NB: PLEASE ATTACH A CERTIFIED COPY OF THE BIRTH CERTIFICATE.

2.3 SPECIFIED CHRONIC CONDITIONS (please indicate which condition(s) are being claimed.

MEDICAL LIFESTYLE		MEDICAL LIFESTYLE PLUS	
End Stage Lung Disease	☐	End Stage Lung Disease	☐
Grand Mal Epilepsy	☐	Grand Mal Epilepsy	☐
Insulin Dependant Diabetes Mellitus	☐	Insulin Dependant Diabetes Mellitus	☐
Parkinson's Disease	☐	Parkinson's Disease	☐
Congestive Heart Failure	☐	Congestive Heart Failure	☐
Cystic Fibrosis	☐	Cystic Fibrosis	☐
Chemotherapy/Radiotherapy	☐	Transplant Organ Protection	☐
Haemodialysis/Peritoneal Dialysis	☐	Chronic Renal Failure	☐
Immunosuppressive Therapy	☐	Cancer	☐

PLEASE ATTACH COPIES OF PRESCRIPTIONS FOR THE PREVIOUS THREE MONTHS, ENSURE THAT THE ATTENDING DOCTOR DOCTOR COMPLETES AND SIGNS 'SECTION 4' OF THIS CLAIM FORM AND SUPPLIES A TREATMENT PLAN.

NB: To qualify for any of these benefits the condition must comply with the definitions as set out in your policy document.

2.4 MOTOR VEHICLE ACCIDENT

Is the claim as a result of a **MOTOR VEHICLE ACCIDENT?** ☐ YES ☐ NO

If "Yes" please provide the following information:

When, where and how did the event occur?

_____

_____

_____

Police Station where reported: _____ Telephone number: _____

Case number: _____ Name of the Investigating Officer: _____

Were you the driver or passenger? ☐ Driver ☐ Passenger

2.5 RECOVERY BENEFIT

2.5.1 (Please indicate which therapy being claimed)

Psychiatric / Psychological Counselling	☐	Dietetic Therapy	☐	Rehabilitation Facility	☐
Occupational Therapy	☐	Chiropractic Therapy	☐	Hospice – Outpatient	☐
Physiotherapy	☐	Home Nursing (by Registered Nurse)	☐	Hospice – In patient	☐
Speech Therapy	☐	Step-down Facility	☐		

2.5.2 **VIOLENT CRIME RECOVERY BENEFIT:**

Date of incident: _____

NB: PLEASE ENSURE THE FOLLOWING ADDITIONAL DOCUMENTATION IS SUBMITTED WITH THIS CLAIM.

- **J88 District Surgeon Form (including criminal case reference number) if there are injuries involved, OR**
- **Sworn Affidavit and the criminal reference number of the case docket if there are no injuries.**

2.6 HOSPITAL AGREEMENT AUTHORISATION FORM

NB. Please ensure that a valid hospital confirmation number has been obtained by the hospital on admission.

I, _____ the Life Assured / signatory of the Claimant's Statement on the above Medical Lifestyle policy issued by Liberty, authorise Liberty to pay R _____ of the benefits which may become payable on the above-mentioned policy to _____ (name of hospital), Practice number _____ . Any remaining benefits are to be paid to the Life Assured.

This authorisation is valid for the benefits arising from processing the accounts incurred as a result of this period of hospitalisation. only. This period being _____ (date of admission) until _____ (date of discharge).

_____
Principal Life Assured's name

_____ _____
Signature Date

SECTION 3 (compulsory for all claims)

DECLARATION

I, the undersigned, 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.

I hereby authorise any medical practitioner, hospital and / or any other person to furnish Liberty, or it's duly authorised representative with any details relating to any illness or injury, both past and present, in respect of the patient or such information that may be deemed necessary to consider this claim.

I hereby authorise Liberty to disclose benefit payment details to any medical service provider who has rendered service in respect of this claim.

Signed at _____ Date _____

_____
Principal Life Assured signature

NB. ONCE AGAIN, WE URGE YOU TO PLEASE CHECK THAT ALL APPLICABLE SECTIONS OF THIS CLAIM FORM ARE COMPLETED AND ALL REQUIREMENTS FOR THE BENEFIT CLAIMED ARE SUBMITTED TOGETHER WITH THIS FORM TO ENABLE THE EFFICIENT PROCESSING OF THE CLAIM.

Your Claims will be processed within five working days provided Medical Lifestyle receives full requirements.
You will be notified if further information is required.