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ShildShare MICROINSURANCE

Because financial protection matters

HOSPITAL CASH PLAN FORM

NOTE: This form must be completed in full. Where a section or field does not apply, indicate "N/A".

SECTION 1: POLICY TYPE

Individual Policy		Burial Society/ Group	
Policy Holders ID/ Name		Burial Society/ Group Name	

SECTION 2: POLICYHOLDER DETAILS

First Name (s)		Surname	
National ID Number		Date of Birth	
Email Address		Mobile Number	
Home Address			

SECTION 3: PATIENTS DETAILS (IF DEPENDANT)

First Name (s)		Surname	
National ID Number		Date of Birth	
Relationship to Policyholder		Mobile Number	

SECTION 4: ADMISSION DETAILS

Date of Hospitalisation		Time of Hospitalisation	
Date of Discharge		Time of Discharge	
Name of Medical Aid		Medical Aid No.	
Reason for Hospitalisation			

SECTION 5: HOSPITAL AND DOCTOR DETAILS

*Name of Hospital			*Hospital Address	
*Hospital Contact Number				
Name of Admitting Doctor			AFHOZ Number	
Name of Discharging Doctor			AFHOZ Number	
Have you ever suffered from the illness you were hospitalised with?	Yes	No	If So, give Dates	

SECTION 6: CLAIM ENTITLEMENT DISCLAIMER

i) Completion of this claim form does not automatically entitle the claimant to receive proceeds from the policy. ShildShare Microinsurance (Private) Limited reserves the right to pay the nominated beneficiary in accordance with the policy Terms and Conditions, which can be found at www.shildshare.com/termsandconditions or at any ShildShare approved customer service touchpoint.

ii) In the event that the nominated beneficiary is unable or unwilling to complete this claim form, they must submit a written letter or affidavit together with their national ID, waiving their right to complete the form and appointing an alternate beneficiary, where applicable.

iii) By signing this form, you consent to the collection, use and processing of personal and medical data strictly for policy administration and claims assessment purposes only, in accordance with Cyber and Data Protection Act [Chapter 12:07] and applicable insurance laws.

SECTION 7: CLAIMANT DETAILS

*First Name (s)		*Surname	
*National ID Number		*Mobile Number	
Email Address		Home Address	
*Signature		*Date	

i) Fraud and Accuracy Reminder: Any misrepresentation, non-disclosure, or fraudulent act by a Policyholder or Beneficiary may result in cancellation of the Policy, rejection of the claim, or forfeiture of premiums or benefits.

ii) We confirm by signing this form that the information provided in this claim form is accurate, complete, and in accordance with the Terms and Conditions of the ShildShare Hospital Cash Back Plan, and we understand that any fraudulent information may result in the rejection of the claim or cancellation of the Policy.

SECTION 8: BENEFICIARY DETAILS

Pay to (Beneficiary Name:		**Contact Number (s)**	

SECTION 9: SELECT PREFERRED PAY-OUT OPTION

Payments to third-party accounts are subject to verification in line with AML/CFT requirements.

Cash	*(Tick)*	**Mobile Money**	*(Tick)*	**Bank Transfer**	*(Tick)*
Collection Point		EcoCash Mobile Number		Account Name	
				Bank Name	
		Account Name		Branch	
				Account Number	
Required Documents	Copies of: Patient card/ Hospital Statement/ Medical Aid Card used/ Receipts for all cash payments/ Letter of admission and discharge/ Discharge Summary/ Test Results/ Diagnosis letter/ Police Report (For Accident)/ Copy of ID of claimant/ Certificate of Medical Attendant				

CERTIFICATE OF MEDICAL ATTENDANT (TO BE FURNISHED AT THE PATIENT'S EXPENSE)

Fraud warning: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Name of Patient	
Reason for Hospitalisation (Diagnosis and Date)	
In Ward Treatment Given	
Known Pre-Existing Conditions and Date of Diagnosis/ Duration of Diagnosis	
1. Conditions	**Date of Diagnosis**
2. Conditions	**Date of Diagnosis**
Medical Questionnaire	
1. Was the admission as a result of a known pre-existing condition? If yes, when was the initial diagnosis done	
2. Is the patient suffering from a chronic condition?	
3. Was admission for the management of pain and or investigation of same?	

DECLARATION

I hereby certify that the above-mentioned information and that the forgoing statements are correct.

Doctors Full Name	**AFHOZ Number**	**Signature**	**Date**

*Doctors Stamp