

## Kelly Group: HOSPITAL CASH PLAN CLAIM FORM

Give full answers to all the questions

Please ✓ where applicable

BLOCK LETTERS PLEASE

### Main Member Details

Surname											First Names																	
ID Number												Age			Sex	M	F	Occupation										
Contact Number	Home					( )					Business					( )					Cell							
Postal Address																												
Physical Address																												

### Employer Details (current employment)

Name of Division within Kelly Group & Branch																									
Employer Name	Kelly Group Ltd																								
Contact Name & Telephone No.	Nomali Khumalo (011) 722-8261 / Lynn Pretorius (011) 722-8258																								
Postal Address	Private Bag X44 Benmore 2010																								
Physical Address	6 Protea Place Sandton Central																								

### Hospitalisation Details

State the Reason for hospitalisation																									
Details of hospital admissions	Hospital Name											Date Admitted						Date Discharged							
	Patient File No											Type of Ward						Telephone & Ext							

(Please attach copy of hospital account)

## Declaration by Main Member/Claimant

I hereby declare that the person mentioned under claim details is nominated under the above-mentioned policy, that all the particulars given are true and complete, and that his / her / my incapacitating condition was not wholly or partly, directly or indirectly caused by the contingencies mention in the exclusions under the conditions of the disability provisions attached to the policy in question.

I further declare that the above statements and answers to the questions under the relevant sections are true and completed in full, that I/we have not withheld any material information and that I/we undertake to furnish any documentation which may be required by the Insurer. I expressly waive all provisions of law, custom or professional etiquette forbidding any physician or any other person attended or examined the patient/deceased or any institution in which the patient/deceased received treatment to disclose any knowledge or information which was thereby acquired and I/we authorise all such persons or agencies to furnish any information in their possession to the Insurer or its authorised representative.

I hereby authorise any hospital, physician or other person who has attended or examined me or my dependants to furnish to Constantia Insurance Company Limited/ Constantia Life and Health Assurance Company Limited or its authorised representative any information with respect to any illness or injury medical history consultation prescriptions or treatment and copies of all hospital or medical records.

Signature of  
Member/Claimant

Date

Signature of Witness

## Payment Instructions

NB: Constantia Insurance Company Limited will not be liable for the loss of funds due to the provision of incorrect banking details by the claimant

Please pay the benefit by EFT directly into the following bank account quoting Reference  
And advise Shanaaz Mathee when the payment is made (Tel: 722- 8010)

### Bank Account Details

Account Holder Name:

**Kelly Group Ltd**

Name of Bank

**FNB**

Type and Number of  
account

**Current Account 6202 4213 168**

Branch Name

**Johannesburg Corporate Branch**

Branch Code

**25 50 05**

*For Office Use Only*

Received by Ambledown Risk and Underwriting Managers (Pty) Ltd

Claim number/s

  

Please fax your claim form and accompanying documents to Ambledown Fax no. 011 463 1665 Tel no. 011 300 1500