Reg No. 2004/006271/07
AMBLEDOWN
RISK AND UNDERWRITING MANAGERS (PTY) LTD
An Authorised Financial Services Provider no: 10287
VAT Reg No: 4340215856

Kelly Group: HOSPITAL INDEMNITY PLAN CLAIM FORM (Accidental Injury Only)

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 Main Member/Claimant		Date		Signature of Witness	1.

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 Telephone no. 011 300 1500