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Reg. No. 1973/008933/06

Ace Insurance is a registered Financial Service
 Provider FSB 00060/01 FAIS 27176

ACE Insurance Limited

MEDICAL TRAVEL CLAIM FORM

- PLEASE USE BLACK INK AND BLOCK CAPITALS
- PLEASE RETURN THE COMPLETED CLAIM FORM TOGETHER WITH ANY ENCLOSURES TO YOUR INSURANCE BROKER OR TO ACE AT THE ADDRESS SHOWN.
- THE COMPLETION AND/OR SUBMISSION OF THIS CLAIM FORM TO US DOES NOT CONSTITUTE AN ADMISSION OF YOUR CLAIM BY ACE INSURANCE LIMITED SOUTH AFRICA

PLEASE ENSURE (✓)	
You fully complete <u>every</u> question contained in this claim form	<input type="checkbox"/>
You have enclosed all requested information/documentation. If not, please ensure that any documentation to follow the submission of this claim, has the policy number written in the top right hand corner.	<input type="checkbox"/>
PLEASE ATTACH TO THIS CLAIM FORM, OR FORWARD AS SOON AS THEY ARE AVAILABLE, COPIES OF THE FOLLOWING DOCUMENTS:	
<ul style="list-style-type: none"> • Copy of your air ticket(s) • Identity document of the Policyholder and or claimant • Proof of medical and or related expenses incurred • Medical report from the attending Doctor 	
You or your legal representative has signed the claim form	<input type="checkbox"/>

1. PERSONAL DETAILS - To be completed by the Policyholder

Certificate/Policy Number:			
Full Name of Policy Holder:		Title:	
Full Name of Claimant:		Title:	
Name of Employer:			
Name of Airline:			
How did you pay for your Air ticket?	<input type="checkbox"/> Cash <input type="checkbox"/> Credit Card		
	Bank:		Card number:
Travel Dates:	Departure:		Return:
	Country of Departure:		Country of Destination:
Date of Birth:		ID No:	
Physical Address:			
Tel. no (Business):		Tel No (Home):	
Fax. No:		Mobile No:	
E-mail:			
Place where the illness/ injury occurred:			
Date on which the illness/ injury occurred:			

2. MEDICAL CLAIM

Did you consult a Medical Practitioner?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Name of Practitioner:			
Tel no:		Fax no:	
Were you hospitalised as an inpatient?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Please provide a medical report from the consulting medical practitioner			
Detailed diagnosis/Nature of the illness/injury:			
Have you ever received any treatment for this or related illness before this claim?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
If YES, please supply Medical Practitioner's report stating what treatment was received 24 months prior to the commencement of your journey.			
Please supply name surname and telephone number of your local Medical practitioner:			
Name of Practitioner:		Tel no:	
Have you notified the Assistance company of your claim?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
If NO, please give reasons why not:			

3. PAYEES BANK DETAILS

Name of your Bank:							6 Digit Branch Code:						
Account holder/name:													
Account no.:													
Address:													

4. DECLARATION AND AUTHORITY

PLEASE NOTE THAT THIS CLAIM FORM WILL ONLY BE ACCEPTED IF THIS DECLARATION HAS BEEN SIGNED BY THE POLICYHOLDER, CLAIMANT OR AUTHORISED PERSON.

I/We _____ declare that all the information is correct and true in every respect and that the signing of this claim form also constitutes written authority for the Company to inspect or investigate any Medical Records or Details relevant to this claim. We further declare that we are aware that any misrepresentation and/or non-disclosure in respect of information provided herein shall render the claim null and void.

I/We _____ authorise any medical practitioner, hospital or other person to provide ACE Insurance Limited with any information they require relating to my medical history and the injury/illness to which the claim relates. I agree that this consent shall remain in force at all times, and that a photo-copy or fax of this declaration shall be accepted as the original. I agree and accept that ACE Insurance Limited may request additional information from any medical practitioner, hospital or any other person not specifically requested herein, on completion and submission of this form and any other documentation as submitted by me.

Signed by the claimant or his/her legal representative on this _____ day of _____ 20_____.

Signature: _____