



Ground Floor, The Bridle
5700
Hunts End Office Park
0812
38 Wierda Road West
Wierda Valley,
Sandton

Tel : +27 11 722-
5700
Fax : +27 11 783-
P.O. Box 1192
Saxonwold
2132

ACE Insurance Limited

www.aceinsurance.co.za

CLAIM FORM

THANK YOU FOR NOTIFYING US OF YOUR CLAIM
PLEASE COMPLETE **ALL** QUESTIONS – IF ANY QUESTION(S) IS NOT APPLICABLE PLEASE STATE "N/A"
PLEASE USE BLACK INK AND BLOCK CAPITALS

Name of Policyholder:	
Certificate/Policy Number:	
Full Name of Insured Person: (Mr, Mrs, Miss, Ms)	
Date of Birth:	I.D. no:
Physical Address:	
Postal Code:	
Tel. no (Business): ()	(Home): ()
Cellphone no:	



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Signed:

Date:

IMPORTANT: THIS CLAIM FORM MUST HAVE THE HOSPITAL STATEMENT COMPLETED AND ACCOMPANIED BY AVAILABLE EVIDENCE OF HOSPITALISATION (E.G. HOSPITAL BILLS ETC.)

HOSPITAL STATEMENT: THIS SECTION MUST BE FULLY COMPLETED BY HOSPITAL MEDICAL STAFF OR RECORDS – ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE INSURED PERSON

Patient's full Name & Surname:
(Mr, Mrs, Miss, Ms)

Date of Birth:

Height:

Weight:

Full details of injuries sustained:

Final diagnosis:

Where did the patient first receive medical attention for the injuries sustained?

Has the patient ever suffered with this or any similar condition before the present episode?

YES/NO

If YES, please give details including dates of treatments and consultations:

Please give name and address of consulting doctor:

Period of Hospitalisation: (Please state full details)

a) Type of hospital/ward:

b) Name of Doctor or Consultant in charge:

c) Dates and Times admitted and released:

Admitted:

Released:

Is there any additional information that you feel is relevant?

Signed:

Position held in Hospital:

Date:

Qualifications:

Please use validation stamp or complete in block capitals:



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Hospital Name:

Validation Stamp

Address:

Telephone no:

Thank you for your assistance in completing this form!

PAYEES BANK DETAILS: When the claim has been approved you may have the payment credited direct to you Bank Account. This payment method is both speedier and safer than by cheque. If you would like to take advantage of this arrangement, please Complete the following:

Name of your Bank:	Branch sort Code: (from the top right hand corner of your cheque)
_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Address:	Account holder/name:
_____	_____
_____	Account no.:
_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Code	

DECLARATION:

I declare that all the information given is to the best of my knowledge and believe, full, true and correct.

Signed: _____ Date: _____

Please list additional information and/or documentation attached to this claim:

PLEASE ENSURE (✓)

You fully complete every question **before** your doctor completes his statement



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- You have enclosed all requested information/documentation
- You have signed the claim form
- Your attending doctor fully completes the statement.

As failure to do so will result in delay in handling your claim. Please return the completed claim form together with any enclosures to your Insurance Broker or to ACE at the Address shown.

Thank you for fully completing this form!