CLIENT REIMBURSEMENT FORM

COMPULSORY SUPPORTING DOCUMENTS TO ATTACH

1. Principal Insured ID copy
2. Bank account verification letter not older than 3 months
3. Proof of Payment
4. Healthcare and / or Service Provider's Account(s)

YOUR PROFILE Principal Insured Details

POLICY NUMBER		TITLE	
NAME		SURNAME	
I.D/PASSPORT NUMBER		CELL NUMBER	
ALTERNATIVE NUMBER		EMAIL ADDRESS	

YOUR CLAIM DETAILS Healthcare and/or Service Provider's Details

☐ HOSPITAL ☐ NETWORK PROVIDER'S CONSULTATION ROOMS ☐ CASUALTY WARD

☐ DENTIST ROOM ☐ GYNAECOLOGIST'S OR SPECIALIST'S ROOMS ☐ OPTOMETRIST'S PRACTICE

PROVIDER NAME/PRACTICE NUMBER	
PATIENT DETAILS	
HOSPITAL ADMISSION DATE OR TREATMENT DATE (WHEN APPLICABLE)	
HOSPITAL DISCHARGE DATE (WHEN APPLICABLE)	
TOTAL CLAIMED AMOUNT	

YOUR CLAIM REIMBURSEMENT PROFILE

Claim reimbursements will be paid into the Principal Insured's bank account. Please note that credit card accounts cannot be accepted.

ACCOUNT HOLDER'S NAME		BANK NAME				
ACCOUNT NUMBER		ACCOUNT TYPE:	CHEQUE		SAVINGS	

SIGNATURE OF ACCOUNT HOLDER

AUTHORISATION & DECLARATION ACCEPTANCE

I hereby authorise any healthcare and/or service provider whom attended to me or any of my dependants and Unity Health or its authorised representatives with information required for the assessment of my claim. I declare that the details and supporting documents provided are true and correct. I understand that any non-disclosure or false representation may result in the rejection of this claim and/or cancellation of cover. I understand that Unity Health will not be held responsible for the loss of funds due to incorrect banking details supplied.

UNITYHEALTH

Unity Health is a division of Ambledown Financial Services (Pty) Ltd. FSP 10287

USE OF PERSONAL INFORMATION DECLARATION

I hereby consent to Unity Health processing my personal information, including but not limited to, the administrative functions listed below.

- Processing this request;
- Processing of future instructions submitted;
- Communications with me in relation to any matters in relation to my policy.

I consent to Unity Health disclosing and transferring my personal information to any contracted third party for the purposes of collecting premiums, claim assessments and statutory reporting in connection with this contract.

I acknowledge I have the right to:

- Object to the processing of my personal information on reasonable grounds unless legislation allows for such processing, in the manner prescribed by the POPI Act;
- lodge a complaint with the Information Regulator;
- request from Unity Health details of any of my personal information Unity Health holds on my behalf and details of how my personal information has been processed.

Unity Health will use its best endeavours to ensure your personal information is reliable, however it remains your responsibility to advise Unity Health of any changes to your personal information in a timely manner. The information supplied to Unity Health must be complete, correct and up to date.

I understand why my personal information is required and the purpose it will be used and I, hereby, give Unity Health consent to process my personal information as provided above.

PRINCIPAL INSURED SIGNATURE	DATE

Please return completed form and supporting documentation to Unity Health
PO Box 1864, Cramerview, 2060
Tel number: 0861 366 006
E-mail address: claims@unityhealth.co.za