CURA
Administrators (Pty) Ltd
An authorised financial services provider – FSP: 26848

Claim Form

Call Centre: 010 021 0260
Fax: 086 743 1363
E-Mail: claims@curaadmin.co.za

Claim Number Office Use Only

1. Policy Holder Details:

Surname		First Names	
ID Number		Cell	
Tel (W)		E-mail Address	
Medical Scheme		Member Number	
Option		Diagnosis	
Cura Policy Number		Cura Product	
Joining Date Office Use Only		Benefit Date Office Use Only	
Service Date		Duration of Hospitalization	

Waiting Period: None ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐

Patient | Date of Birth

Relationship to Principal Insured: Self ☐ Spouse ☐ Child ☐

Reason for Claiming: Accident ☐ Illness ☐ Surgical ☐ Childbirth ☐ Natural Death ☐ Unnatural Death ☐

2. Bank Details of Beneficiary: No third party / credit card

Account Holder's Name			
Bank Name		Branch Name	
Account Number		Branch Code	

Account Type: Current Account ☐ Transmission Account ☐ Savings Account ☐

Account Holder Signature _____

I declare that the above particulars are true in every respect and I attach or will forward as soon as possible copies of all hospital and service provider accounts and relevant medical aid statements. I hereby authorise any hospital, physician or other person who has attended to or examined me or my dependants, to furnish to the Cura or its authorised representative any information with respect to any illness or injury, medical history, consultations or treatment and copies of all hospital or medical records. A Photostat copy of this authorisation shall be considered as effective and valid as the original.

Principal Insured Signature _____ Date _____

Brokerage		Broker Representative	

Please Attach:
Hospital / Doctor Account
Medical aid statement, reflecting the date of service
Proof of payment of co-payment
Proof of bank account details - not older than 3 months