

Contact details

Tel: 0860 11 33 22, PO Box 652509, Benmore 2010, www.discovery.co.za

International travel ITB travel claim form

Who we are

The University of KwaZulu-Natal Medical Scheme (referred to as 'the Scheme'), registration number 1520, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

- Please complete this form when claiming for any emergency medical expenses incurred while travelling outside the borders of South Africa, in accordance with the Scheme's rules.
- Please use one letter per block, complete with black ink and print clearly.
- To avoid administrative delays, please make sure this form is completed in full.
- Please submit all supporting claims or documentation along with this form.
- You need to report/submit all claims within 60 days of your return to South Africa or within 3 months, if living outside the borders of SA.
- Please attach a copy of your passport with entry and exit stamps or air tickets. If you are permanently living abroad and have previously submitted proof of residency, you do not need to resubmit this information.
- To submit your claim please fax to 0860 329 252.
- To follow up, contact 0860 11 33 22 or 031 576 7015.

1. Travel and personal information

Membership number	<input type="text"/>	Reference number	<input type="text"/>
Departure date	<input type="text"/>	Return date	<input type="text"/>
Do you live outside the borders of SA?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Did you buy your ticket by credit card?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes , please supply the name of your bank	<input type="text"/>		
Do you have independent travel insurance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Patient's surname	<input type="text"/>		
Patient's first names	<input type="text"/>		
Patient's date of birth	<input type="text"/>		
Postal address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		Code <input type="text"/>
Physical address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		Code <input type="text"/>
Telephone (W)	<input type="text"/>	Fax	<input type="text"/>
(H)	<input type="text"/>	Cellular	<input type="text"/>
Email	<input type="text"/>		

2. Details of medical aid related expenses incurred

Date of illness/injury/admission to hospital

Country of illness/injury

Cause of illness/injury/diagnosis/symptoms

Treatment or medicine received

Full name of doctor consulted

Name of hospital admitted to

Total amount claimed for foreign currency

Currency (for example US dollars, Cypriot pounds)

Did you settle these accounts yourself? Yes No

Have you previously received treatment or attention for this illness/condition in South Africa? Yes No

3. Details of your treating doctors in South Africa

1. Doctor's name

Telephone Fax

2. Doctor's name

Telephone Fax

Brief explanation of medical incident – details of cause of illness eg car accident (Dates of admission and discharge, medication and treatment rendered.)

	Date of service	Dependant	Treatment	Claimed amount
1.	<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"/>
2.	<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"/>
3.	<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"/>
4.	<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"/>
5.	<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"/>
6.	<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"/>

4. Declaration

I declare that the above information is true in every respect.

Name in full

Signature

Date

**Please do not sign an incomplete application form
I confirm the information is accurate and complete**