



PHYSICAL ADDRESS: Block B, Western Entrance,  
Lynnwood Corporate Park, 36 Alkantrant Road,  
Lynnwood Ridge, 0081  
POSTAL ADDRESS: PO Box 1115, Bromhof, 2154  
TEL: 010 599 1170 | FAX: 086 664 1062  
EMAIL: applications@wesmart.co.za

## CLAIM FORM

Compliance Officer: Moonstone Compliance (Pty) Ltd  
Financial Services Provider: (FSP 45769)

### PRINCIPAL INSURED DETAILS

Please complete this form in black ink and CAPITAL letters

Name and Surname:

ID number / Passport:  Policy Number:

Date of birth:  Email Address:

Contact details: Home no.:  Work no.:   
Fax no.:  Cell no.:

Postal address:   
 Code:

Residential address:   
 Code:

Submitted Documents: Claim form  Dr's account  Hospital account  Proof of co-payment  Other

Admission date:  Discharge date:

### BANK DETAILS

Name of account holder:

Account no.:

Bank:  Standard Bank  ABSA  FNB  Nedbank  Capitec  Other

Account type:  Cheque  Savings  Transmission  Other

Debit order day:  1st  5th  7th

Signature of account holder  Date:

### BANKING DETAILS FOR REFUNDS

Name of account holder:

Account no.:

Bank:  Standard Bank  ABSA  FNB  Nedbank  Capitec  Other

Account type:  Cheque  Savings  Transmission  Other

Debit order day:  1st  5th  7th

Signature of account holder  Date:

### DECLARATION BY APPLICANT

- I, the undersigned, hereby declare:
- That to the best of my knowledge and belief the information provided in connection with this application whether in my own handwriting or not, is true and I have not withheld any material facts which are known to me. (A material fact is likely to influence the assessment of this application by WESMART Financial and Administration Solutions (Pty) Ltd. If you are in any doubt as to whether a fact is material or not, you should disclose it.)
  - That I understand that any relevant material fact omitted in this proposal form may lead to WESMART Financial and Administration Solutions (Pty) Ltd not meeting claims, should the omitted fact have been of such importance that the risk may not have been accepted in the first instance, in terms of the policy. This may lead to the cancellation of this policy or rejection of claims without refund of premiums.
  - That I understand that this is an Accident and Health policy with stated benefits in terms of the Short-term Insurance Act 53 of 1998 and not a Medical Scheme product.
  - The sharing of claims information and underwriting information by insurers is essential to enable the insurance industry to underwrite policies, assess risks fairly, reduce the incidence of fraudulent claims and protect the public interest in terms of limiting excessive premium increases. You hereby waive any right to privacy of any insurance information provided by you or on your behalf, in respect of any insurance policy or claims you lodge. You also consent to such information being disclosed to any other insurance company and/or verified against other legitimate source or a database.
  - I specifically consent to WESMART Financial and Administration Solutions (Pty) Ltd contacting my current medical practitioner to verify any medical details as provided in my application form. I further consent to such information being disclosed to WESMART Financial and Administration Solutions (Pty) Ltd for purpose of verifying the disclosure as provided on my application form.
  - That I will advise WESMART Financial and Administration Solutions (Pty) Ltd of any changes to my health state between the point of application and actual inception of my policy.
  - As part of our claims validation process we use the services of a contracted third party in order to authenticate relevant beneficiaries and other relevant information to validate the claim.
  - We reserve the right to call for additional information of a clinical nature, in the event that WESMART requests a PMA (Post Medical Assessment) from your doctor as part of the claims assessing and authentication process
  - I authorise WESMART Financial and Administration Solutions (Pty) Ltd to negotiate with service providers on my behalf for my medical claims and or bill and pay the provider direct.
  - By agreeing to the terms of this consent form, I expressly consent to the processing of my information for marketing purposes and know & understand that by agreeing to same that I may on occasion, receive marketing materials in the form of sms and / or emails and the like from WESMART Financial and Administration Solutions (Pty) Ltd.

Signature of policy holder  Date:

Spouse (if married in community of property)  Date:

PLEASE NOTE - WESMART Financial and Administration Solutions (Pty) Ltd must be notified within 90 days of any occurrence which may give rise to a claim. Claims will NOT be considered for assessment without the following documentation:

- A fully completed, signed claim form.
- Clear copies of all account statements.
- Hospital account

All documents must be submitted within 90 days.  
All policy terms apply to each claim submitted.

