



**Contact details** 

Tel: 0860 100 693 • PO Box 652509, Benmore 2010 • www.avgms.co.za

## International claim form

## Who we are

The Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571, 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 medical expenses incurred while travelling outside the border of South Africa, in accordance with the Scheme's rules.
- Please use one letter per block, complete in black ink and print clearly.
- Please submit all supporting claims or documentation to service@discovery.co.za or fax to 0860 329 252 with this completed ITB claim form.
- You need to report or 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.
- To follow up, or for more information, contact 0860 100 693.

1. Travel and perse	onal info	ormation	l									
Membership number					Re	eference ni	umber					
Departure date	D D	M M Y	Y	′ Y		Retu	n Date	D M M	Y   Y   Y			
Are you living outside t	he boarde	rs of SA?			Yes	No	Did	you purchase	your ticket v	a credit card?	Yes	No
If yes, please supple th	ne name c	of the bank	(									
Do you have independe	ent travel i	nsurance'	?		Yes	No						
Patients surname												
Patients name(s) (as pe	er identity de	ocument)										
Patients date of birth	D D	M M Y	Y	Y								
Postal address												
										Code		
Physical address												
										Co	de	
Telephone (W)								Fax				
Telephone (H)								Cellphone				

2. Details of medical aid related	d expenses incurred												
Date of illness/injury/admission to hos	pital D M M Y Y Y												
Country of illness/injury													
Cause of illness/injury/diagnosis/symp	otoms												
Treatment or medication received													
Full name of doctor consulted													
Name of hospital													
Total amount claimed in foreign current	cy eg US dollars, Cipriate pounds												
Did you settle these accounts yourself?  Yes  No													
	nt or attention for this illness/condition in Se	outh Africa? Yes No											
3. Details of your treating docto	ors in South Africa												
Doctor's name													
Telephone		Fax											
Doctor's name		_											
Telephone		Fax											
Brief explanation of medical incident (C	Cause of illness/injury, dates of admission	and discharge, medication and treatmen	nt given.)										
Date of service	Dependant	Treatment	Claimed amount										
1. D D M M Y Y Y Y													
2. D D M M Y Y Y Y													
3. D D M M Y Y Y Y													
4. D D M M Y Y Y Y													
5. D D M M Y Y Y Y													
6. D D M M Y Y Y Y													
4. Declaration													
I declare that the above information is	true in every respect.												
Name in full													
-	-1												
Signatory		Date D - M	<u>M</u> - <u>Y Y Y Y</u>										
	not sign an incomplete application form he information is accurate and complete												