

International Claims Form

Please complete this form when claiming for any medical expenses you had to pay while travelling outside South Africa.

Who we are

Engen Medical Benefit Fund (referred to as 'the Fund'), registration number 1572, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the Administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

How to complete this form

1. Please use one letter per block, complete with black ink and print clearly. Alternatively, complete it digitally.
2. To avoid administrative delays, please ensure this form is completed in full.
3. Please send the following supporting documentation to claims@engenmed.co.za with this completed claim form:
 - Copies of claims for medical expenses.
 - Proof of payment of all claims submitted.
 - A copy of your passport showing entry and exit stamps and/or flight tickets.
4. Please make sure you send all claims within 120 days of the date of service to avoid the claims being rejected as late submissions to the Fund.

When you sign this form, you confirm that the information provided is true and correct.

1. Travel and personal information

Membership number	<input type="text"/>																														
Departure date	<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"/>	<input type="text"/>	Return date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>													
Are you living outside the borders of SA?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Did you purchase 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 names (as per identity document)	<input type="text"/>																														
Patient's date of birth	<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>														
Postal address	<input type="text"/>																														
<input type="checkbox"/> PO Box	<input type="checkbox"/> Private bag	Box number	<input type="text"/>																												
<input type="checkbox"/> Suite	<input type="checkbox"/> PostNet suite	Box	<input type="text"/>																												
Suburb	<input type="text"/>																														
City	<input type="text"/>													Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>													
Physical address	<input type="text"/>																														
Unit/Suite number	<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Complex name	<input type="text"/>												
Street number	<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Street name	<input type="text"/>												
Suburb	<input type="text"/>																														
City	<input type="text"/>													Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>													
Telephone (H)	<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Telephone (W)	<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cellphone	<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>														
Email	<input type="text"/>																														

