Lusaka PO Box 30337, Lusaka, Zambia | Corner of Kafue Road and Mahogany Drive, Lilayi, Lusaka
Kitwe PO Box 20324, Kitwe, Zambia | Plot No 698, Corner of 1 Paulo Close and Nationalist Way, Kitwe
South Africa 139 Greenway, Greenside, Randburg, Johannesburg, 2193
Website www.ses-unisure.com | **Tel** +260 967 770 304 | **Unisure Assist** +27 87 238 2600

REIMBURSEMENT CLAIM FORM

IMPORTANT INFORMATION

Please return this form with the necessary documentation (e.g. receipts/invoices/medication prescription) to **payandclaim@ses-unisure.com**

It is your responsibility to retain any original supporting documentation (e.g. receipts/invoices) where copies are submitted to us, as we reserve the right to request original supporting documentation/receipts up to 12 months after claims settlement for fraud detection purposes.

Please note that claims payment can be delayed if all sections of the claim form are not completed in full.

1. MEMBER INFORMATION *Please complete the application in BLOCK CAPITALS

Membership Number

ZA _____ Title _____ Gender ☐ Male ☐ Female

First Name _____ Surname _____

Email _____ Mobile _____

2. MEDICAL DETAILS

Please select the type of treatment received

Elective ☐ Emergency ☐ Follow-Up ☐ Dental ☐ Wellness ☐

Please provide full details of the symptoms/medical conditions and treatment received:

Date of Treatment
DD/MM/YYYY _____

In what country did the treatment take place? _____

Please select the procedures done by doctor/specialist

Consultation ☐ Laboratory ☐ Radiology ☐ Pharmacy ☐ Admission ☐

3. CLAIM DETAILS

Please complete all parts of the following table with the details of each invoice and receipt.

Please include the amount charged and invoice currency.

Description of expense/treatment	Providers Name	Amount Charged	Invoice Currency

4. PAYMENT DETAILS

Preferred payment method	☐	Bank Transfer	☐ Cheque
Bank Name			
Account Name/Payee			
Account Number			
Currency			
SWIFT/BIC Code			
IBAN			
Bank Address			

5. DECLARATION

PLEASE READ THIS SECTION CAREFULLY

For us to process your claims, we will need to apply for a medical report from any doctor who has attended to you. To apply, we need you to give your consent by signing the declaration below. Personal data collected from you and where appropriate, your family, will be used by Specialty Emergency Services to process your claims and administer your policy.

Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including Hospitals General Practitioners, Physicians, or other health providers, and if applicable, to any person or organisation who may be responsible for meeting your treatment expenses.

TO BE COMPLETED BY THE PATIENT/ PARENT

- I confirm that the information I have given on this form is accurate and correct to the best of my knowledge.
- I confirm that I give explicit consent to obtain and process my medical information with respect to my claims.

Patient Name

Date
DD/MM/YYYY

Signature

HOW TO SUBMIT YOUR CLAIM

- Please return this form with the necessary documentation (e.g. receipts/invoices/medication prescription) to **payandclaim@ses-unisure.com**
- You can also submit your claim form by clicking on the "**Submit**" button on the right

Submit

CONTACT US

SES 24/7 Zambia contact number **737**

SES Zambia WhatsApp **+260 969 416 888**

Pre-Authorisation **737**

Claims **payandclaim@ses-unisure.com**

SES International Numbers **+260 962 740 300** / **+260 977 770 302** / **+27 82 485 7491**

Unisure Assist South Africa **+27 87 238 2600**