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

APPLICATION FOR FOLLOW-UP APPOINTMENT

IMPORTANT INFORMATION FOR MEMBERS:

- Please return this form with the necessary documentation to **assist@ses-unisure.com**
- Please ensure that the relevant sections are fully completed, as incomplete applications will not be processed
- SES will do its utmost to accommodate the preferred Date/Doctor/Facility but cannot guarantee that such requests will be satisfied
- Securing an appointment is often a time-consuming process. Once an appointment date has been set, it cannot be changed
- If a member misses an appointment for any reason, without prior approval, that member is liable to meet the full cost of the appointment

Membership Number: SES Plan

Group Name:
(If applicable)

Endorsements: ☐ Yes ☐ No

Please complete the application in BLOCK CAPITALS

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr

First Name: Last Name:

Date of Birth: DDMMYYYY Age:

Gender: ☐ M ☐ F

Mobile Number:

Email Address:

Telephone Number:

Please complete the application in BLOCK CAPITALS

* The term 'Follow-Up' refers to a medical or surgical treatment review with the same treating physician or surgeon.

PLEASE SELECT THE TYPE OF FOLLOW-UP APPOINTMENT TO BE MADE

☐ Post-surgery ☐ Chronic Condition ☐ Other

Please provide full details of the symptoms or medical condition requiring treatment:

If the follow-up is post-surgery, please indicate the date that the surgery was conducted: DDMMYYYY

If the follow-up is ongoing treatment, please indicate the onset date of treatment: DDMMYYYY

Name of Treating Physician:

Name of Hospital/Clinic:

Possible dates when you would like the appointment made? DDMMYYYY Other: DDMMYYYY

Preferred Country: ☐ South Africa ☐ India ☐ Zimbabwe ☐ Other

CONSENT TO OBTAIN A MEDICAL REPORT

- For SES to process your claim, we need to apply for a medical report from any doctor who has attended to you. In order to apply, we need you to provide consent by signing the declaration below.
- Personal data collected with regards to you or your health, and/or where appropriate, your family, will be used by Specialty Emergency Services to process your claim and administer your policy.
- All medical information obtained 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 organization that may be responsible for meeting your treatment expenses.
- Specialty Emergency Services uses a third party to process data on its behalf. This processing is subject to contractual restrictions regarding confidentiality and security.
- All forms and medical reports received will be disclosed to the duly authorized agent acting on our behalf.

I, the undersigned, _____ agree to waive any rights that I may possess to medical secrecy or confidentiality in respect of my medical information, and therefore authorize and request that any hospital, physician, or other health providers furnish Specialty Emergency Services, or its duly authorized agent acting on behalf of Specialty Emergency Services, with relevant medical information relating to any treatment or other services rendered to me.

DECLARATION

IF THIS APPLICATION IS FOR A MINOR, A PARENT OR GUARDIAN SHOULD SIGN THIS SECTION.

TO BE COMPLETED BY THE PATIENT OR PARENT:

I confirm that the information I have provided on this form is accurate and correct, to the best of my knowledge.

I confirm that I grant explicit consent within the document, to obtain and process my medical information with respect to my claims.

I confirm that I have read and understood the terms and conditions set out in this document.

By checking this box, I electronically sign my application. ☐

Patient's Name:

Date: DDMMYYYY

Patient Signature:

Please contact our call center by dialling **737** if you have any queries, or email: **assist@ses-unisure.com**