REFUND CLAIM FORM

Service Provider

Employer/ Account Holder | Date D D M M Y Y Y Y

Member's Details

Surname | First Names

Gender ☐ Male ☐ Female | Date of Birth D D M M Y Y Y Y

Medical Aid Package: Starter ☐ Starter+ ☐ Standard ☐ Classic ☐ Classic+ ☐ Active ☐ Vitality ☐ Zest ☐

Member Number

Physical Address

Home Phone Number | Work Phone Number

Mobile Number | Email Address

Patient's Details

Surname | First Names

Gender ☐ Male ☐ Female | Date of Birth D D M M Y Y Y Y

Relationship to Member

Member Number | Patient's Suffix

Medical Claim Details

	EXPENSE TYPE	DAY	MTH	YR	MEMBER'S SIGNATURE	QUANTITY	AMOUNT
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
						TOTAL CLAIM	

Expense Type: e.g. Prescription Drugs, X-ray Service

Member's Signature.. Date D D M M Y Y Y Y

NB: Please attach receipts from the Service Provider for any cash refund claims.

FOR OFFICIAL USE ONLY

Members Limit | Excess

Claim Authorised by: | Date D D M M Y Y Y Y

Claim Processed by: | Date D D M M Y Y Y Y

Maisha Health Fund

Bank Details

Steward Health Fund

Name of Member:..

Membership No:..

BANK DETAILS

Bank: ....

Branch:..

Branch Code:..

A/C Number:..

A/C Name:..

Physical Address:..

....

Contact Person:..

Signature ....

Contact Number:..

Tel: 0242701935-8