BENEFIT WALLET CLAIM FORM

Tel: +264 83 299 9000
E-mail a copy of the completed form to: claims@prosperitynam.com

Renaissance Health
Medical Aid Fund

Section A - Principal Member Details

Member Number		Date of Birth	D D M M Y Y Y Y
First Name		Surname	
Telephone Number		Cellphone Number	
E-mail Address		Product Joining Date	D D M M Y Y Y Y
Postal Address			

Section B - Patient Details

Member Number		Date of Birth	D D M M Y Y Y Y
First Name		Surname	
Relationship to Member		Diagnosis	

Section C - Claims Detail
(attach copies of all related claims)

Claims To Be Paid To
(member refund must be accompanied by proof of payment to Health Professional)

Health Professional	Date of Treatment	Claimed Amount	Health Professional				Member			
			YES		NO		YES		NO	
			YES		NO		YES		NO	
			YES		NO		YES		NO	
			YES		NO		YES		NO	
			YES		NO		YES		NO	
			YES		NO		YES		NO	
			YES		NO		YES		NO	
			YES		NO		YES		NO	

Section D - Bank Details *(For EFT Claim Refunds) (Attach proof of bank account details)*

IMPORTANT NOTICE: It is compulsory to supply Renaissance Health Medical Aid Fund with this information.

Name of Account Holder							
Bank Name						Branch Code	
Type of Account	Cheque		Transmission		Savings	Account Number	

Section E - Declaration

Signature		Date	D D M M Y Y Y Y

Section F - For Office Use Only

Assessor Name		Validator Name	
Date Assessed		Date Checked	
Signature		Signature	

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