

Health4Me Bloom funeral claim form

Claim requirements

- Fully completed Health4Me funeral claim form.
- Certified (by a commissioner of oaths) copy of the insured life's identity document/passport/birth certificate.
- Certified (by a commissioner of oaths) copy of the insured life's death certificate.
- Certified (by a commissioner of oaths) copy of the BI 1663 (obtainable from the doctor who certified the death).
- Certified (by a commissioner of oaths) copy of the beneficiary's/claimant's identity document/passport/birth certificate.
- If the deceased child does not bear the same surname as the member, proof in the form of an affidavit of the relationship.
- If the deceased is a spouse, a certified (by a commissioner of oaths) copy of the marriage certificate.
- If the marriage certificate is not available, proof in the form of an affidavit that a permanent life partnership existed.
- Copy of the beneficiary's/claimant's bank statement (not older than 3 months) or cancelled cheque. Please note that ATM or internet statements are not acceptable.
- Additional information may be required.
- Claims not submitted within four months of the claim event will be rejected.
- Please submit the completed and signed form and any supporting documents, via email to health4meinsuranceclaims@momentum.co.za.

1: Main member's details

Membership number	<input type="text"/>
First name	<input type="text"/>
Surname	<input type="text"/>

2: Deceased's details

First name	<input type="text"/>		
Surname	<input type="text"/>		
ID number/passport number	<input type="text"/>	Gender	<input type="text"/> Male <input type="text"/> Female <input type="text"/>
Date of death	<input type="text"/>		
Cause of death	<input type="text"/>		
Relation to main member	<input type="text"/>		

3: Claimant's details

First name	<input type="text"/>		
Surname	<input type="text"/>		
ID number/passport number	<input type="text"/>	Gender	<input type="text"/> Male <input type="text"/> Female <input type="text"/>
Contact number	<input type="text"/>		
Email address	<input type="text"/>		
Address	<input type="text"/>		Postal code <input type="text"/>
Relation to deceased	<input type="text"/>		

4: Claimant's banking details

Name of account holder	<input type="text"/>		
Name of bank	<input type="text"/>		
Account number	<input type="text"/>		
Account type	<input type="text"/> Current/Cheque <input type="text"/>	<input type="text"/> Savings <input type="text"/>	<input type="text"/> Transmission <input type="text"/>
Branch code	<input type="text"/>	Branch name	<input type="text"/>

5: Member consent

I authorise Momentum Metropolitan Life Limited to:

- Obtain from Momentum Health Solutions (Pty) Ltd or any health service provider any medical information relating to an insurance claim, so that Momentum Metropolitan Life Limited can assess and evaluate a claim in terms of the policy. I hereby authorise Momentum Health Solutions (Pty) Ltd or any health service provider to release the required information to Momentum Metropolitan Life Limited.
- Share any information required between Momentum Metropolitan Life Limited, Momentum Health Solutions (Pty) Ltd and any other health service provider.
- Disclose my medical information to any parties that Momentum Metropolitan Life Limited has contracted with in order to provide services in respect of the policy.

I accept and understand that my consent to the disclosure of medical information may impact on my right to privacy. This consent shall remain in force for the full duration of my membership, unless it is expressly withdrawn by me. I understand that Momentum Metropolitan Life Limited will not disclose any medical information without my consent. I understand that the consent will only apply for the purpose indicated above and will not be shared with other parties.

Signature of claimant	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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