

# BENEFIT WALLET CLAIM FORM

Tel: +264 83 2999 543

E-mail a copy of the completed form to: rhmafmember@prosperitynam.com



## 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	

## 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	

prosperity-2020