

International Claims Form

Please complete this form when claiming for any medical expenses you paid while travelling overseas.



Contact details

Tel: 0860 002 133 • www.sabmas.co.za

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the Administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly. Alternatively, complete it electronically.
2. To avoid administrative delays, please ensure this form is completed in full.
3. Please email this completed and signed form to **claims@sabmas.co.za**. The following must be included with this form:
 - Copies of claims for medical expenses
 - Proof of payment for all claims submitted
 - A copy of your passport showing entry and exit stamps and/or flight tickets.
4. Please make sure you send all claims within 120 days of the date of service to avoid the claims being rejected as late submissions to the Scheme.

When you sign this form, you confirm that the information provided is true and correct.

1. Travel and personal information

Membership number										
Departure date	D	D	M	M	Y	Y	Y	Y		
Return date	D	D	M	M	Y	Y	Y	Y		
Are you living outside the borders of SA?	Yes	☐	No	☐	Did you purchase your ticket via credit card?	Yes	☐	No	☐	
If yes, please supply the name of the bank										
Do you have independent travel insurance?	Yes	☐	No	☐						
Patient's surname										
Patient's first names (as per identity document)										
Patient's date of birth	D	D	M	M	Y	Y	Y	Y		
Postal address (Post collected from post box, suite or private bag)										
☐ PO Box	☐ Private Bag	Box number								
☐ Suite	☐ Postnet Suite	Number								
Suburb										
City								Postal code		
Physical address										
Suite/Unit number					Complex name					
Street number					Street name					
Suburb										
City								Postal code		
Telephone (W)					Telephone (H)					
Cellphone										
Email										

2. Details of medical and related expenses incurred

D	D	M	M	Y	Y	Y	Y
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[illegible]No ☐No ☐

3. Details of your treatment received while travelling

Date of service									Dependant	Treatment	Claimed amount					
1.	D	D	M	M	Y	Y	Y	Y								
2.	D	D	M	M	Y	Y	Y	Y								
3.	D	D	M	M	Y	Y	Y	Y								
4.	D	D	M	M	Y	Y	Y	Y								
5.	D	D	M	M	Y	Y	Y	Y								
6.	D	D	M	M	Y	Y	Y	Y								

4. Declaration

D	D	M	M	Y	Y	Y	Y
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Please do not sign an incomplete application form
I confirm the information is accurate and complete

Please note that all international claims will be refunded in South African Rands and not in the currency that you have paid. The allocation of benefits will be subject to the Scheme Rules and the benefits according to your chosen benefit option.