

Membership Number / Expiry Date

In accordance with the Health International Terms & Conditions, as stated in the Membership Guide Section 10, any Member visiting a medical facility for the purpose of EMERGENCY treatment is required to do the following:-

- A. **NOTIFY THE REGIONAL OFFICE WITHIN 72 HOURS OF THE EVENT** (by telephone / email / text / visit).
- B. **COMPLETE THIS EMERGENCY CLAIM FORM AND SUBMIT TO THE CLAIMS DEPARTMENT** (see details below).
- C. **MEMBERS ARE REMINDED THAT SHOULD THIS CASUALTY VISIT BE A NON-EMERGENCY / OUT-PATIENT CLAIM, IT MAY BE DECLINED. IF YOU ARE UNSURE, KINDLY CALL THE CLAIMS DEPARTMENT ON THE FOLLOWING NUMBER +260 (0) 966 853 948.**

Failure to comply with the above will lead to repudiation of the claim.

**MEMBERS INFORMATION: (As Per Your Health International Membership Card)**

Name of Principal Member:

Contact Telephone No:  Mobile:

Full Name of Patient:

Patient Date of Birth:  /  /

Membership No:  Membership Expiry Date:

**COMPLETION OF THIS SECTION IS COMPULSORY:**

**REASON FOR EMERGENCY VISIT:** Please Tick The Applicable Box  ACCIDENT  ILLNESS

**DATE OF EMERGENCY:**  **TIME OF EMERGENCY:**

**FULL DESCRIPTION OF THE EMERGENCY:**

Name of Emergency Facility:

Name of Treating Doctor or Specialist:

(PLEASE INCLUDE CONTACT DETAILS IF AVAILABLE)

INVESTIGATIONS RELATED TO THE EMERGENCY:		
RADIOLOGY (X-RAY / MRI SCAN / C.T. SCAN ETC.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PATHOLOGY (BLOODS / SPECIMEN URINE / STOOL ETC.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Member's Signature \_\_\_\_\_ Date (DD / MM / YY) \_\_\_\_\_ Place: \_\_\_\_\_

I understand that Health International will collect and process my personal data as per Clause 9.10 of the Terms and Conditions.