

# International Travel Benefit (ITB) claim form

Please complete this form when claiming for any medical expenses you had to pay while travelling overseas.



## Contact details

Tel: 0860 100 698 • PO Box 8012, Greenstone 1616 • [www.malcormedicalaid.co.za](http://www.malcormedicalaid.co.za)

## Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

## How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administrative delays, please ensure this form is completed in full.
3. Please email the following supporting documentation to [service@malcormedicalaid.co.za](mailto:service@malcormedicalaid.co.za) or fax to **0860 329 252** or **+27 11 539 7001** with this completed ITB claim form:
  - Copies of claims for medical expenses
  - Proof of payment of 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 application form, you confirm the information you have given is true and correct.

## 1. Travel and personal information

Membership number	<input type="text"/>	MSOI Reference number	<input type="text"/>
Departure date	<input type="text"/>	Return Date	<input type="text"/>
Do you live outside the borders of SA?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Did you buy your ticket by credit card?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "Yes", please supply the name of your bank	<input type="text"/>		
Do you have independent travel insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Member's surname	<input type="text"/>		
Member's first names (as per identity document)	<input type="text"/>		
Member's date of birth	<input type="text"/>		
Postal address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		Code <input type="text"/>
Physical address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		Code <input type="text"/>
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>		
Email	<input type="text"/>		

## 2. Details of medical and related expenses incurred

Date of illness, injury or admission to hospital

Country where illness or injury happened

Full name of doctor consulted

Name of hospital admitted to

Total amount claimed in foreign currency for example US dollars, euro etc.

Did you settle these accounts yourself? Yes  No

Have you received treatment or attention for this illness or condition in South Africa before? Yes  No

## 3. Details of your treating doctors in South Africa

1. Doctor's name

Telephone         Fax

2. Doctor's name

Telephone         Fax

Brief explanation of medical incident and details of cause of illness or injury for example car accident  
(Dates of admission and discharge, medication and treatment received)

	Date of service	Dependent	Treatment	Claimed amount
1.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
2.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
3.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
4.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
5.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
6.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

## 4. Declaration

I declare that the information is true and correct.

Signed at (town or city)  on

Signature of main member  Main member must sign and date any changes

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