CELLMED HEALTH
MEDICAL FUND

EX-GRATIA CLAIM AUTHORISATION FORM

Date: dd/mm/yyyy

Requested by:

Background:

Recommendation

APPROVAL

RECOMMENDED BY (CLAIMS MANAGER):

Full name:

Signature: SIGN HERE

Date: dd/mm/yyyy

FINANCE MANAGER:

Requested by:

Signature: SIGN HERE

Date: dd/mm/yyyy

HEAD OF OPERATIONS:

Requested by:

Signature: SIGN HERE

Date: dd/mm/yyyy

GCEO:

Requested by:

Signature: SIGN HERE

Date: dd/mm/yyyy

ADJUSTMENT EFFECTED BY:

Requested by:

Signature: SIGN HERE

Date: dd/mm/yyyy

VALIDATION DONE BY (ADJUDICATOR):

Requested by:

Signature: SIGN HERE

Date: dd/mm/yyyy

CELLMED HEALTH
MEDICAL FUND