Member
Refund Form

In the event of any member requiring a refund, this form must be completed.

Please attach the following documents to your claim

1. **Detailed account** from your service provider and a **receipt**
2. Pharmacy claim: a **script print out**, and a **cash slip**

Please email your claim to: **claims@eeb.co.za**

Date completed:	

Member Surname	
Policy Number	
Identity Number	
Patient Name	
Birthdate	
Name of service provider	
Practice Number	
Date of service	
Reason for refund	

Amount charged	R	Amount paid	R

Member banking details

Account name			
Account no			
Bank			
Branch		Branch code	
Contact number (work)		Cell phone	

Signature

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