2021

TRAUMA COUNSELLING CLAIM FORM

Stratum Benefits

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Title | Name

Surname

ID/ Passport | Contact Numbers | or

Email Address

PATIENT DETAILS

◯ Please indicate if the patient is the principal insured, in which case the below details aren't required.

Title | Name

Surname | ID/Passport

Medical Aid | Medical Aid No.

Medical Aid Option

2. TRAUMA EVENT DETAILS & COUNSELLING DATES (To be completed by your Trauma Counsellor)

*Our **TRAUMA COUNSELLING COVER** applies when counselling is necessary due to one or more of the below events. Please indicate for which event counselling is, or was necessary.*

◯ My patient has witnessed / is directly affected by an act of physical violence or an accident

◯ My patient mourns the death of a loved one

◯ My patient received word of a loved one's / their own diagnosis of a critical illness

◯ Other

Counselling Date / /

3. TRAUMA COUNSELLOR DECLARATION

As the Trauma Counsellor treating, or who has treated the patient, I hereby declare that the information provided is true and correct.

Trauma Counsellor Name

Practice Number

Practice Stamp / Trauma Counsellor Signature

4. YOUR CLAIM REIMBURSEMENT PROFILE

The bank account details that you provide in this section will be the bank account we'll make a claim payment into. We don't accept any responsibility or liability for claim payments made into an incorrect bank account that you've provided.

Bank | Account Number

Account Holder

Account Type

◯ Cheque ◯ Savings

Account Holder Signature

AUTHORISATION & DECLARATION ACCEPTANCE

I declare that the details and supporting documents submitted are true and correct. I understand that non-disclosure or false representation may result in the rejection of this claim or the cancellation of cover.

I hereby authorise my medical aid and healthcare providers, where applicable, to provide Stratum Benefits or their authorised representatives with any information that they require to assess my claim.

Principal Insured Signature

Date / /