

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. MEDICAL HISTORY (To be completed by your treating Healthcare Provider)

Date cancer was diagnosed / / Type of cancer diagnosed (ICD10 Code)

Is this the first cancer ever diagnosed in the patient's lifetime? Yes No If "No", confirm the date when cancer was diagnosed the first time / /

If "No", provide more information about the cancer that was previously diagnosed

Is the most recent diagnosed cancer in remission? Yes No If "Yes", confirm the remission date / /

Please confirm the following details regarding the cancer **currently** being treated:

The neoplasm is: Benign Malignant

Stage of cancer: Stage 1 Stage 2 Stage 3 Stage 4

3. HEALTHCARE PROVIDER DECLARATION

As the Healthcare Provider treating, or who has treated the patient in question, I hereby declare that the information provided is true and correct.

Healthcare Provider Name

Practice Number Discipline

Practice Stamp

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

5. AUTHORISATION & DECLARATION ACCEPTANCE

I hereby authorise my medical aid and any Healthcare Provider whom attended to me or any of my dependants to furnish **Stratum Benefits (Pty) Ltd** and / or their authorised representatives with information required for the assessment of my claim. I declare that the details and supporting documents provided are true and correct. I understand that any non-disclosure or false representation may result in the rejection of this claim and / or cancellation of cover.

Principal Insured Signature Date / /

Email: yourclaim@stratumbenefits.co.za