

2023 GAP COVER CLAIM FORM

Claims for our **FIRST-TIME CANCER DIAGNOSIS BENEFIT** and **TRAUMA COUNSELLING BENEFIT** require specific claim forms. Go to www.stratumbenefits.co.za/gap-cover-downloads/ to download the claim forms or request it from us.

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
ID/Passport No.	<input type="text"/>			Date of Birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D
Cellphone No.	<input type="text"/>			Alternative Contact No.	<input type="text"/>
Email Address	<input type="text"/>				

PATIENT DETAILS

Please let us know if the patient is also the principal insured, in which case the below details won't be required.

Title	<input type="text"/>	Name	<input type="text"/>	Surname	<input type="text"/>
ID/Passport	<input type="text"/>			Date of Birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D
Relationship	<input type="text"/>			Medical Aid	<input type="text"/>
Medical Aid Plan	<input type="text"/>			Membership No.	<input type="text"/>

2. YOUR CLAIM DETAILS

MEDICAL EVENT DETAILS (Provide details of the investigation, medical procedure or surgery that was performed, or treatment that was provided.)

Admission or Treatment Date	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D	Discharge Date (if hospitalised)	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D
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Have you received discounts from any of the healthcare or service providers related to this claim? If "Yes", please let us know who the providers are. Yes No

Healthcare or Service Provider	<input type="text"/>	Healthcare or Service Provider	<input type="text"/>
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Do you know if any further payments will be made by your medical aid to any of the healthcare or service providers related to this claim? If "Yes", please let us know who the providers are. Yes No

Healthcare or Service Provider	<input type="text"/>	Healthcare or Service Provider	<input type="text"/>
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CONTACT DETAILS OF YOUR HEALTHCARE PROVIDER

General Practitioner	<input type="text"/>	Contact No.	<input type="text"/>
Treating or Referring Healthcare Provider	<input type="text"/>	Contact No.	<input type="text"/>

3. YOUR CLAIM REIMBURSEMENT PROFILE

The approved claim amount will be paid into the bank account number provided. We won't accept any responsibility or liability for a claim payment made into an incorrect bank account.

Bank	<input type="text"/>	Account No.	<input type="text"/>
Account Holder	<input type="text"/>	Account Type	<input type="text"/> Cheque <input type="text"/> Savings
Account Holder Signature	<input type="text"/>	Date	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D

4. POLICYHOLDER AUTHORISATION & CONSENT

When entering this policy, I agreed to share information with **Stratum Benefits** for underwriting and claims purposes and authorised them to process my data to effect the administration of my policy.

Stratum Benefits may share personal data about myself and my dependants, where applicable, with my healthcare providers. I authorise my medical aid and healthcare providers to provide **Stratum Benefits** and their authorised representatives with any information needed to assess my or my dependants' claims.

I accept that my healthcare and service providers may be contacted to negotiate reduced fees to ensure I maintain a suitable risk profile. The provider will be paid directly if a discount is granted and the claim is approved.

If I pay my provider after my claim has been submitted, I accept that **Stratum Benefits** won't arrange a refund on my behalf or pay me the difference between the amount claimed and the amount my provider discounted unless I inform **Stratum Benefits** of such payment.

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

Principal Insured Signature	<input type="text"/>	Date	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y - <input type="text"/> M <input type="text"/> M - <input type="text"/> D <input type="text"/> D
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Email yourclaim@stratumbenefits.co.za

Please contact us if you haven't received feedback within **10 working days** from submitting your claim form.