2023 CLAIM FORM | FIRST-TIME CANCER DIAGNOSIS BENEFIT

Stratum Benefits

Go to www.stratumbenefits.co.za/first-time-cancer-diagnosis-benefit/ to view or download our First-Time Cancer Diagnosis Benefit guide for more information about the qualifying criteria.

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Title | Name | Surname

ID/Passport No. | Contact No.

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 No. | Medical Aid

Medical Aid Plan | Membership No.

2. MEDICAL HISTORY *(For your treating Healthcare Provider to complete)*

Please provide the required medical details as indicated below:

Date cancer was diagnosed (Y Y Y Y - M M - D D) | 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 (Y Y Y Y - M M - D D)

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 (Y Y Y Y - M M - D D)

Confirm the following details regarding the cancer currently being treated:

Neoplasm is: Benign ◯ Malignant ◯ | Stage of cancer: ◯ Stage 1 ◯ Stage 2 ◯ Stage 3 ◯ Stage 4

Have cancerous cells invaded surrounding or underlying tissue? ◯ Yes ◯ No

Is the patient registered on a medical aid oncology programme / treatment plan? ◯ Yes ◯ No

3. HEALTHCARE PROVIDER DECLARATION

As the Healthcare Provider who's treating/treated the patient, I hereby declare that the information provided is true and correct.

Healthcare Provider Name | Practice No.

Discipline | Contact No.

Practice Stamp

4. YOUR CLAIM REIMBURSEMENT PROFILE

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

Bank | Account No.

Account Holder | Branch

Account Type ◯ Cheque ◯ Savings | Account Holder Signature

5. AUTHORISATION & DECLARATION ACCEPTANCE

As the principal insured, 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.
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 dependant's claim.

Principal Insured Signature | Date (Y Y Y Y - M M - D D)

Email **yourspecialisedclaim@stratumbenefits.co.za**
Please contact us if you haven't received feedback within **10 working days** from submitting your claim form.