2024 GAP COVER CLAIM FORM

Stratum Benefits

*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 | Name | Surname

ID/Passport No. | Date of Birth (Y Y Y Y - M M - D D)

Cellphone No. | Alternative Contact No.

Email Address

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 | Name | Surname

ID/Passport | Date of Birth (Y Y Y Y - M M - D D)

Relationship | Medical Aid

Medical Aid Plan | Membership No.

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 (Y Y Y Y - M M - D D) | Discharge Date (if hospitalised) (Y Y Y Y - M M - D D)

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 | Healthcare or Service Provider

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? ◯ Yes ◯ No
If "Yes", please let us know who the providers are.

Healthcare or Service Provider | Healthcare or Service Provider

CONTACT DETAILS OF YOUR HEALTHCARE PROVIDER

General Practitioner | Contact No.

Treating or Referring Healthcare Provider | Contact No.

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 | Account No.

Account Holder | Account Type ◯ Cheque ◯ Savings

Account Holder Signature | Date (Y Y Y Y - M M - D 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 | Date (Y Y Y Y - M M - D D)

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