Stratum Benefits

2024 HEALTH INSURANCE | MEMBER REIMBURSEMENT FORM

COMPULSORY SUPPORTING DOCUMENTS TO ATTACH

1. Principal Insured's ID/Passport
2. Principal Insured's Bank Statement not older than 3 months
3. Healthcare or Service Provider's Account
4. Proof of payment

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Policy Number

Title | Name | Surname

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

Cellphone No. | Alternative Contact No.

Email Address

2. YOUR CLAIM DETAILS

MEDICAL EVENT DETAILS

- ◯ Casualty
- ◯ Dentistry
- ◯ Network GP Consultation
- ◯ Pre-Birth Maternity / Specialist Consultation
- ◯ Specialist Consultation
- ◯ Hospital
- ◯ Optometry
- ◯ Pathology
- ◯ Radiology
- ◯ Out-of-Network GP Consultation

Hospital Admission Date (if applicable) or Treatment Date (Y Y Y Y - M M - D D)

Hospital Discharge Date (if applicable) (Y Y Y Y - M M - D D)

Reason for consulting an out-of-network GP

3. YOUR CLAIM REIMBURSEMENT PROFILE

Claim reimbursements will be made into the principal insured's bank account provided below. Proof of banking details, the principal insured's identification document and proof of payment of the service provider's account are required.

If payment must be made into a bank account other than the principal insured's, the principal insured must submit an affidavit authorising the Company to reimburse the person noted.

Bank | Account Number

Account Type ◯ Cheque ◯ Savings | Account Holder

Account Holder Signature

4. AUTHORISATION & DECLARATION ACCEPTANCE

1. I authorise any healthcare or service provider, who attended to me or any of my dependants, to provide Unity Health and their authorised representatives with any information that they require to assess my claim.
2. I declare that the details and supporting documents provided are true and correct.
3. I understand that any non-disclosure or false representation may result in the rejection of this claim and/or cancellation of cover.
4. I give permission to Unity Health and their authorised representatives to obtain and process my, or my dependants' personal information. I understand why personal information may be required and the purpose it will be used for.
5. I understand that I have the right to request Unity Health to verify the personal information they hold and how my personal information has been processed. I further understand that I can lodge a complaint with the Information Regulator.
6. I accept that Unity Health won't be held responsible for the loss of funds if I provide incorrect banking details.

Principal Insured Signature

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

Email **yoursupport@stratumbenefits.co.za**
Please contact us if you haven't received feedback within **7 working days** from submitting the reimbursement form.