2025 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.

Submit this claim form only when all standard tests and diagnostic procedures have been performed and a final diagnosis has been made.

1. POLICYHOLDER & PATIENT DETAILS

POLICYHOLDER DETAILS

Title | Name | Surname

ID/Passport No. | Contact No.

Email Address

PATIENT DETAILS

◯ Please indicate if the patient is the policyholder, 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 THE TREATING HEALTHCARE PROVIDER TO COMPLETE

Have all standard tests and diagnostic procedures been performed to confirm the cancer diagnosis relevant to this claim? ◯ Yes ◯ No

If "Yes", please submit a copy of the histology report confirming the diagnosis date.

Date cancer was diagnosed (Y Y Y Y - M M - D D) | Type of cancer diagnosed *(ICD10 Code)*

Has the patient previously been diagnosed with cancer? ◯ Yes ◯ No | If "Yes", confirm the diagnosis date (Y Y Y Y - M M - D D)

If "Yes", provide details of the previously diagnosed cancer

Is the most recent diagnosed cancer in remission? ◯ Yes ◯ No | If "Yes", confirm the remission date (Y Y Y Y - M M - D D)

CANCER CURRENTLY BEING TREATED

Neoplasm Type ◯ Benign ◯ Malignant | Cancer Stage ◯ Stage 1 ◯ Stage 2 ◯ Stage 3 ◯ Stage 4

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

3. HEALTHCARE PROVIDER DECLARATION

As the healthcare provider currently treating or who has previously treated the patient, you confirm that the information provided is true and correct.

Healthcare Provider Name | Practice No.

Discipline | Contact No.

Practice Stamp

4. CLAIM REIMBURSEMENT DETAILS

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.

Only provide details of your or the claimant's banking details.

◯ Debit Order Bank Account *(Select this option if the approved claim amount must be paid into the same bank account from which you're debited. This option is not applicable if your employer pays your policy premiums on your behalf.)*

◯ Alternative Bank Account

Bank | Account No.

Account Holder | Account Type ◯ Cheque ◯ Savings

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

5. POLICYHOLDER DECLARATION & AUTHORISATION

As the policyholder, you 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 your claim and cancellation of cover.

You authorise your medical aid and healthcare provider to provide us and our authorised representatives with any information needed to assess your claim.

Policyholder Signature | Date (Y Y Y Y - M M - D D)

Send the completed claim form to us at: **yourspecialisedclaim@stratumbenefits.co.za**

Please contact us if you haven't received feedback within **4 working days** of submitting your claim form.