1. STANDARD REQUIREMENTS

Claims must be submitted within **6 months** from the date of a claimable event. A claimable event date is when a medical procedure is performed, treatment is provided, an investigation is done, or the date you're discharged from the hospital.

Submit the following documents when claiming:

- Completed and signed claim form. **Please complete and submit one claim form for every medical event date or admission period.**
- Service and healthcare providers' invoices relevant to your claim, reflecting the ICD-10 codes and procedure/tariff codes.
- Medical aid statement reflecting the service and healthcare providers relevant to your claim.
- Bank statement or verification letter dated not older than **3 months**.

Claims for our FIRST-TIME CANCER DIAGNOSIS BENEFIT and TRAUMA COUNSELLING BENEFIT require specific claim forms, as your healthcare provider or counsellor have specific sections to complete, sign or stamp.

Our **Claim Submission Guide** provides more information about the typical supporting documents required to assess claims.

Go to www.stratumbenefits.co.za/gap-cover-downloads/ or scan the **QR code** to view the **Claim Submission Guide** or to download the claim forms.

We may ask for additional documents to finalise the assessment of your claim.

2. POLICYHOLDER & PATIENT DETAILS

POLICYHOLDER 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 tick the box if the patient is also the policyholder, in which case the details below aren't required.

Title | Name | Surname

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

Relationship | Medical Aid

Medical Aid Plan | Membership No.

3. CLAIM DETAILS

MEDICAL EVENT DETAILS

Provide details of the investigation, medical procedure or surgery, or treatment provided.

Where did your medical event take place? ◯ Day Clinic ◯ Hospital ◯ Healthcare Provider's Room ◯ Casualty Ward ◯ Other

Medical Event / Admission Date *(if hospitalised)* (Y Y Y Y - M M - D D) | Discharge Date *(if hospitalised)* (Y Y Y Y - M M - D D)

Healthcare / Service Provider	Healthcare / Service Provider Contact Details	Amount Being Claimed	Has the healthcare / service provider granted you a discount? Yes / No	Are further payments due by your medical aid? Yes / No

SUPPORTING DOCUMENT CHECKLIST

The checklist helps remind you of the supporting documents you must submit to help us accurately assess your claim, as specified in the **Claim Submission Guide**.

◯ Day Clinic / Hospital Invoice ◯ Healthcare / Service Provider Invoice ◯ Medical Aid Statement ◯ Other

HEALTHCARE PROVIDER CONTACT DETAILS

Please complete the details below as this may be required in certain instances, such as referring your claim to your medical aid for an enquiry or review or if we investigate for a pre-existing medical condition or non-disclosure.

General Practitioner | Contact No.

Referring / Treating Healthcare Provider | Contact No.

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

When you entered this policy, you agreed to share information with **Stratum Benefits** for underwriting and claims purposes and authorised us to process your information to administer your policy. This authorisation includes sharing personal information about you and your dependants with your healthcare providers and authorising your medical aid and healthcare providers to provide us and our authorised representatives with any information needed to assess your claim.

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

If you pay your provider after submitting a claim, you accept that we won't arrange a refund or pay you the difference between the claimed amount and the provider's discount unless you inform us of such payment.

As the policyholder, you confirm that the details and supporting documents submitted are true and correct and accept that non-disclosure or false representation may result in the rejection of your claim and cancellation of cover.

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

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

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