2025 CLAIM FORM TRAUMA COUNSELLING BENEFIT | Stratum Benefits

Go to www.stratumbenefits.co.za/gap-cover-downloads/ to view or download our **TRAUMA COUNSELLING BENEFIT** guide for more information about the qualifying criteria.

1. POLICYHOLDER & PATIENT DETAILS

POLICYHOLDER DETAILS

Title | Name | Surname

ID/Passport No. | 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. | Medical Aid

Medical Aid Plan | Membership No.

2. TRAUMA EVENT DETAILS & COUNSELLING DATES

FOR THE TRAUMA COUNSELLOR TO COMPLETE

Our **TRAUMA COUNSELLING BENEFIT** applies when counselling is necessitated by specific traumatic events. Please indicate which event pertains to your patient.

◯ Witnessed / directly affected by an accident or act of physical violence

◯ Received news of a loved one's / own diagnosis of a critical illness *(Please specify)*

◯ Mourns the death of a loved one

◯ Other *(Please specify)*

Counselling Date Y Y Y Y - M M - D D

3. TRAUMA COUNSELLOR DECLARATION

As the trauma counsellor currently consulting or who has consulted with the patient, you confirm that the information provided is true and correct.

Trauma Counsellor Name | Practice No.

Practice Stamp / Authorised Signatory

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 corect 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 providers 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** from submitting your claim form.