2021

GAP COVER CLIENT CLAIM FORM

Stratum Benefits

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Title | Name

Surname

ID/ Passport | Contact Number

Email

PATIENT DETAILS

○ Please indicate if the patient is the principal insured, in which case the below details aren't required.

Title | Name

Surname

ID/ Passport | DoB / / | Relation

Medical Aid | Medical Aid Option | Medical Aid Number

2. YOUR CLAIM DETAILS

MEDICAL EVENT DETAILS

Please provide details of the investigation, medical procedure, surgery or treatment that was performed or provided.

Admission or Treatment Date / / | Discharge Date (if hospitalised) / /

Have you received a discount from any of the healthcare or service providers related to this claim? If so, please let us know who the provider is. ○ Yes ○ No

Healthcare or Service Provider | Contact No.

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? If so, please let us know who the provider is. ○ Yes ○ No

Healthcare or Service Provider | Contact No.

CONTACT DETAILS OF YOUR HEALTHCARE PROVIDER

General Practitioner | Contact No.

Treating or Referring Healthcare Provider | Contact No.

3. YOUR CLAIM REIMBURSEMENT PROFILE

The bank account details that you provide in this section will be the bank account we'll make a claim payment into. We don't accept any responsibility or liability for claim payments made into an incorrect bank account that you've provided.

We reserve the right to negotiate a discount with your healthcare or service provider to help maintain a good risk profile. Only if your provider agrees to a discount will we pay them directly.

Please submit proof of payment if you've paid your provider directly. If we negotiate a discount and pay your provider without knowing that you've already made payment, we won't facilitate a refund or assist with the difference between the claimed amount and the discount granted.

Bank | Account Number

Account Holder

Account Type

○ Cheque ○ Savings

Account Holder Signature | Date / /

AUTHORISATION & DECLARATION ACCEPTANCE

I declare that the details and supporting documents submitted are true and correct. I understand that non-disclosure or false representation may result in the rejection of this claim or the cancellation of cover.

I hereby authorise my medical aid and healthcare providers, where applicable, to provide Stratum Benefits or their authorised representatives with any information that they require to assess my claim.

Principal Insured Signature | Date / /

Email: **yourclaim@stratumbenefits.co.za**.

CONSTANTIA Insurance made personal

Stratum Benefits (Pty) Ltd, an authorised FSP 2111, is underwritten by Constantia Insurance Company Limited, an authorised FSP 31111.

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