Stratum Benefits

2022 GAP COVER | CLAIM FORM

*If your claim is for our **First-Time Cancer Diagnosis Benefit** and/or **Trauma Counselling Cover**, specific claim forms must be completed for each benefit. Visit our website to download the applicable form or contact us for assistance.*

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Title | Name

Surname

ID/ Passport | Contact Numbers | or

Email Address

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 Plan | Medical Aid Number

2. YOUR CLAIM DETAILS

MEDICAL EVENT DETAILS

Provide details of the investigation, medical procedure or surgery that was performed, or treatment that was 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, 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, 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 approved claim amount will be paid into the bank account number provided. We don't accept any responsibility or liability for a claim payment made into an incorrect bank account.

We may contact your healthcare or service provider to request a discount to help maintain a good risk profile. If granted, we'll pay your provider directly once the claim is approved. If you've already paid your provider but didn't inform us, a refund won't be facilitated nor will we pay the difference between the claimed amount and the discounted amount.

Bank | Account Number

Account Holder

Account Type

◯ Cheque ◯ Savings

Account Holder Signature | Date – –

4. 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 any claim and/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 need to assess my claim.

Principal Insured Signature | Date – –

Email **yourclaim@stratumbenefits.co.za**
Please enquire if you've not received feedback within **10 working days** from submitting the Claim Form

CONSTANTIA Insurance made personal

t 010 593 0981 www.stratumbenefits.co.za