

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Title	<input type="text"/>	Name	<input type="text"/>
Surname	<input type="text"/>		
ID/ Passport	<input type="text"/>	Contact Numbers	<input type="text"/> or <input type="text"/>
Email	<input type="text"/>		

PATIENT DETAILS

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

Title	<input type="text"/>	Name	<input type="text"/>
Surname	<input type="text"/>		
ID/ Passport	<input type="text"/>	DoB	<input type="text"/> / <input type="text"/> / <input type="text"/> Relation <input type="text"/>
Medical Aid	<input type="text"/>	Medical Aid Option	<input type="text"/> Medical Aid Number <input type="text"/>

2. YOUR CLAIM DETAILS

MEDICAL EVENT DETAILS

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

<input type="text"/>

Admission or Treatment Date	<input type="text"/> / <input type="text"/> / <input type="text"/>	Discharge Date (if hospitalised)	<input type="text"/> / <input type="text"/> / <input type="text"/>
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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	<input type="text"/>	Contact No.	<input type="text"/>
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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	<input type="text"/>	Contact No.	<input type="text"/>
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CONTACT DETAILS OF YOUR HEALTHCARE PROVIDER

General Practitioner	<input type="text"/>	Contact No.	<input type="text"/>
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Treating or Referring Healthcare Provider	<input type="text"/>	Contact No.	<input type="text"/>
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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	<input type="text"/>	Account Number	<input type="text"/>
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Account Holder	<input type="text"/>
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Account Type
 Cheque Savings

Account Holder Signature	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
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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	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
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Email: yourclaim@stratumbenefits.co.za