2019

Stratum Gap Cover

CLIENT CLAIM FORM

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Title | Name | Surname | ID or Passport Number

Medical Aid | Medical Aid Option | Membership Number

Cellphone Number | Alternative Contact Number

Email Address

PATIENT DETAILS

◯ Please indicate whether the Patient is the Principal Insured, in which case the below details are not required.

Title | Name | Surname | ID or Passport Number | Relationship

Medical Aid | Medical Aid Option | Membership Number

2. YOUR CLAIM DETAILS

MEDICAL EVENT DETAILS

Medical procedure, surgery, treatment or investigation that was performed or provided.

Admission or Treatment Date DD/MM/YYYY

Discharge Date (if hospitalised) DD/MM/YYYY

Have you received a discount from any Healthcare Provider related to this claim? If so, please provide details of the relevant Healthcare Provider. ◯ Yes ◯ No

Healthcare Provider | Contact No

Are you aware of any further payments due by your medical aid to any Healthcare Provider related to this claim? If so, please provide details of the relevant Healthcare Provider. ◯ Yes ◯ No

Healthcare 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

We reserve the right to negotiate a discount with your Healthcare Provider(s) on your behalf as this will assist with ensuring a favourable risk profile. Should your Healthcare Provider agree, payment will be made directly to your Healthcare Provider and this section will no longer apply. Banking details provided in this section will be the only bank account used for claim reimbursements. We accept no responsibility or liability for any incorrect banking details provided in this section.

◯ Please indicate whether claim reimbursements should be made into the same account from which your Stratum Benefits policy premiums are debited.

◯ Please indicate whether claim reimbursements should be made into an alternative bank account by completing the payment details below. Should you nominate your Healthcare Provider's account for direct payment but a discount has not been negotiated between your Healthcare Provider and ourselves, the claim refund amount will be paid into the debit order account we have on record. We will contact you for your debit order account details should we not have these details on record.

Account Holder | Bank | Account Number

Account Type ◯ Cheque ◯ Savings

Account Holder Signature

AUTHORISATION & DECLARATION ACCEPTANCE

I hereby authorise my medical aid and any Healthcare Provider whom attended to me or any of my dependants to furnish Stratum Benefits (Pty) Ltd and / or their authorised representatives with information required for the assessment of my claim. I declare that the details and supporting documents provided are true and correct. I understand that any non-disclosure or false representation may result in the rejection of this claim and / or cancellation of cover.

Principal Insured Signature | Date DD/MM/YYYY