Stratum Gap Cover

2019

FIRST-TIME CANCER DIAGNOSIS CLAIM FORM

Our client wishes to claim from an **ONCOLOGY BENEFIT** offered on their Gap Cover policy for which medical information is required.

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. MEDICAL HISTORY (To be completed by the treating Healthcare Provider)

Date cancer was diagnosed

Type of cancer diagnosed (ICD10 CODE)

Is this the first time cancer has ever been diagnosed? ◯ Yes ◯ No

If no, please provide date of first-time cancer diagnosis

Please provide details of previously diagnosed cancer where applicable

Is the most recently diagnosed cancer in remission? ◯ Yes ◯ No

If yes, please provide provide confirmed date of remission

Please confirm the following regarding the cancer currently being treated:

Is the neoplasm? ◯ Benign ◯ Malignant

Stage of cancer ◯ Stage 1 ◯ Stage 2 ◯ Stage 3 ◯ Stage 4

3. HEALTHCARE PROVIDER DECLARATION

As the Healthcare Provider who diagnosed the patient in question, I hereby declare that the information provided is accurate and true.

Healthcare Provider Name | Practice Number

Discipline | Signature

Practice Stamp / Authorised Signatory

Date

4. YOUR CLAIM REIMBURSEMENT PROFILE

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.

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