Stratum Gap Cover

2019

TRAUMA COUNSELLING CLAIM FORM

Our client wishes to claim from a **TRAUMA COUNSELLING 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. TRAUMA EVENT DETAILS (To be completed by the treating Healthcare Provider)

The qualifying criteria for our **TRAUMA COUNSELLING BENEFIT** are based on specific events as listed below. Please select the reason that necessitates(d) trauma counselling.

My patient has witnessed/is directly affected by an act of physical violence or an accident.

My patient received word of a loved one's/their own diagnosis of a dread disease.

My patient mourns the death of a loved one.

Other

3. HEALTHCARE PROVIDER DECLARATION

As the Healthcare Provider who is treating/treated 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

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