2020

FIRST-TIME CANCER DIAGNOSIS CLAIM FORM

Stratum Benefits Gap Cover

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Title | Name

Surname | ID/Passport

Medical Aid | Medical Aid No.

Medical Aid Option

Cellphone | Alternative Contact No.

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/Passport

Medical Aid | Medical Aid No.

Medical Aid Option

2. MEDICAL HISTORY (To be completed by your 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:

The neoplasm is? ◯ Benign ◯ Malignant

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

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

Practice Stamp / Healthcare Provider Signature

4. YOUR CLAIM REIMBURSEMENT PROFILE

The bank account details that you provide in this section will be the bank account details that we use for claim payments. We do not accept any responsibility and/or liability if claim payments are made into an incorrect bank account number that you have provided.

We reserve the right to negotiate a discount with your Healthcare Provider(s) on your behalf to help maintain a favourable risk profile. If your Healthcare Provider(s) agrees to a discount, only then will we pay them directly.

Bank | Account Number

Account Holder

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