2020

CLIENT CLAIM FORM

Stratum Benefits Gap Cover

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Title | Name | Surname

ID/ Passport | Contact Number

Email

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 | Relationship

Medical Aid | Medical Aid Option | Medical Aid Number

2. YOUR CLAIM DETAILS

MEDICAL EVENT DETAILS

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

Admission or Treatment Date | Discharge Date (if hospitalised)

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

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 | Date

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