Sanlam Gap Cover Claim form

In order for a claim to be valid, there are certain basic criteria that have to be met. These include, but are not limited to:

- Your contributions being paid up;
- You being a member of a valid South African medical scheme;
- You having been hospitalised (certain procedures such as an Endoscopic procedure, CT Scan and Chemotherapy does not require hospitalisation - Please refer to your policy document for the listed outpatient procedures that are covered);
- Your procedure not involving drug/alcohol rehabilitation or admission for depression or dental implants (please refer to the policy document for a full list of exclusions);
- Having obtained an authorisation number for the procedure from your medical scheme;
- Your specialist, ie your surgeon or your anaesthetist, having charged a higher rate than your medical scheme reimbursement rate, ie you having a shortfall;
- Your medical scheme option requiring you to pay a co-payment or upfront deductible (If a benefit is provided), not related to the use of providers or authorisation/referral processes (unless a benefit is provided);
- You receiving accidental emergency treatment (as defined in the master policy) in a hospital casualty ward, and your medical scheme not covering this from the in-hospital risk portion of your medical scheme;
- You having exceeded your limit for oncology treatment;
- Your medical scheme option requiring you to pay a co-payment for oncology treatment.

Once you have established that you have a valid claim, you will be required to complete this Sanlam Gap Cover claim form. Please note that this is not an automatic process, and you will be required to submit a separate claim form to the claim that has been submitted to your medical scheme.

When submitting the claim form, you will also need to provide a copy of the relevant specialists' accounts, hospital accounts and medical aid statement showing the processing of the accounts and the shortfall. Please note that the claim will not be processed until all documents have been received. You have 6 months from the first day that you were hospitalised to submit your claim and relevant documentation. Any claim received for the first time after the 6 month period has expired, will not be honoured. Should a portion of the documentation be received within the 6 month period, the claim will be held pending for a further four month period, after which it will go stale and will not be honoured.

Claims can be e-mailed to **sanlamclaims@kaelo.co.za**.

Once received, your claim will be processed and if all requirements have been met, the benefit amount will be paid within 7 to 10 working days.

Please also remember that this policy does not form part of your medical scheme and your medical scheme call centre will thus not be able to assist you with any questions in this regard.

Please direct all queries to our Customer Care Centre on **0861 111 167**.

Sanlam Gap Cover is underwritten by Centriq Insurance Company Limited.
Administered by Kaelo Risk (PTY) LTD

SPF1419 06/2019

T 0861 111 167
C 086 501 8521
E sanlaminfo@kx.co.za
www.sanlamgapcover.co.za

Sanlam Gap Cover Claim form

Important note

Complete, sign and return the claim form to sanlamclaims@kaelo.co.za.

A. Principle Member Details

Title: _____ Initials: _____

Surname: _____ Name: _____

Employer Name: _____ ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Medical Aid Name: _____ Medical Aid Plan: _____

Medical Aid No: _____ Policy No: GAP _____

Cell Number ☐☐☐☐☐☐☐☐☐☐ Home Number ☐☐☐☐☐☐☐☐☐☐

Work Number ☐☐☐☐☐☐☐☐☐☐ Email Address: _____

Postal Address: _____

_____ Code ☐☐☐☐

B. Payment Instructions

No payments will be made to credit card accounts

Bank Name: _____ Account No: _____

Branch Code: _____ Account Holder Name: _____

Account Type: ☐ Cheques ☐ Transmission ☐ Savings

Account Holder Signature: _____

Payments will only be made to the Principle Member's Account. Date ☐☐☐☐☐☐☐☐

The company will not be liable for the loss of funds due to the provision of incorrect bank details by the member.

C. Cession

We would like to contact your relevant Medical Doctor or specialist to negotiate a discount on your outstanding account and pay them directly, if you are comfortable for us to do so, please complete this section.

I, (full name) _____ with ID No ☐☐☐☐☐☐☐☐☐☐☐☐☐

(hereinafter called the cedent) am the legally entitled owner of policy number _____

I hereby cede, transfer, assign and make over unto:

Doctor 1: _____

Doctor 2: _____

Doctor 3: _____

Doctor 4: _____

the benefit entitlement under this policy that relates to the claim/s for treatment administered by the above practice at hospital _____ on the date _____on the express condition that any outstanding account that relates to the above treatment and medical practice are fully settled by this cession.
No other benefit entitlement is ceded under this cession.

Policy Holder Signature: _____ Date ☐☐☐☐☐☐☐☐

D. Patient Details

Title: _____ Initials: _____

Surname: _____ Name: _____

Cell Number ☐☐☐☐☐☐☐☐☐☐ ID Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Relationship: ☐ Self ☐ Spouse ☐ Child Other: _____

Email Address: _____

E. Where did the incident Occur

Did the procedure take place: ☐ In-Hospital ☐ Doctors Rooms ☐ Casualty Ward

Was the hospitalisation as a result of an accident?: ☐ Yes ☐ No

Hospital/Service Provider Name: _____

Procedure Details/Reason for hospitalisation: _____

Admission / Event Date ☐☐☐☐☐☐☐☐ Discharge Date ☐☐☐☐☐☐☐☐

F. Event Details

Service Date	Doctor's Name	Doctor's Practice No	Doctor's Charged Amount	Medical Scheme paid	Shortfall you are claiming

G. Claims Checklist

In order for us to assess your claim without any delays, please ensure you have the following documents:

Tariff Shortfalls; Co-payments & deductibles; Oncology; Sub-limit Enhancer; Dental Reconstruction

- Claim Form ☐
- Claims Transaction History (Request from Scheme) ☐
- Hospital Account (Request from hospital) ☐
- Relevant Doctor's Account (Request from Doctor) ☐

Accidental Casualty

- Claim Form ☐
- Claims Transaction History (Request from Scheme) ☐
- Hospital Account (Request from hospital) ☐
- Relevant Doctor's Account (Request from Doctor) ☐

Family Protector/ Contribution Waiver

- Claim Form ☐
- Death Certificate ☐
- ID of claimant & deceased ☐
- Accident Report (If accidental) ☐

Family Booster

- Claim Form ☐
- Letter confirming expected delivery date & actual delivery date (Request from Doctor) ☐

Hospital Booster

- Claim Form ☐
- Hospital Account (Request from hospital) ☐

Please note that your claim cannot be assessed until you have submitted all the relevant documentation.

H. Declaration by Principal Member

I, (full name) _____ hereby declare that this application form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Underwriter and myself. I hereby apply for the insurance product/s and agree to abide by its policy rules and/or those of its Underwriter and any amendments thereto which may be made from time to time. I confirm that all the information provided herein is complete and true and that I have not concealed any relevant or pertinent information that may affect the evaluation of risk considered under this policy of cover. I understand that the provision of any false, misleading or missing information could result in my application being rejected or my membership being canceled or claims being rejected. Should this occur, I agree to refund all benefit payments that I have received in relation to this policy of insurance. In the event that my employer to make such cover nomination of my behalf and furthermore indemnify Sanlam Gap Cover and the underwriter against liability for any loss that may result from an incorrect nomination of such cover by the employer. I hereby provide irrevocable authority for Sanlam Gap Cover and its Underwriter to obtain any of my or my beneficiaries' medical history from any Medical Service Provider, medical scheme, insurance company or healthcare intermediary for the purposes of assessing this application for insurance as well as the underwriting of any future risk or the assessment of any claim that relates to this insurance cover. Premiums due to Centriq are payable monthly. Premiums that are in arrears will result in my membership being suspended or possibly terminated. In the event that any policy benefit becomes payable subsequent to or as a result of my death, I hereby provide an irrevocable authority for such benefits to be paid directly to my surviving spouse or failing such circumstance to the nominated guardians or trustees responsible for the future care of my minor children or failing either of the preceding events to my estate. Where applicable, I hereby authorise Centriq to draw against the above bank account all amounts due to Centriq in terms of this insurance cover. Should the relevant premiums be adjusted by the underwriters, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outline in the policy document. This request is to remain in force unless canceled by one month's written notice. Where my employer deducts the premium from my salary I hereby provide authority for my Employer to deduct such premium and pay this across to Centriq. I accept that any notice given to my employer is deemed to have been given to me.

Full Name: _____ Signature: _____

Date: D D M M Y Y Y Y