

How to submit a claim

Firstly, please ensure that you complete the claim form in full and sign it. The form can be found below on page 2 of this document.

- **Claims transaction remittance from your medical scheme:**

Since a gap claim involves covering certain amounts not covered by your medical scheme, we need to be able to see what your medical scheme has paid and obviously how much they have paid for each and every claim amount. Please ensure that the details of each service provider is detailed on the remittance, e.g. surgeon, anaesthetist, hospital, etc.

- **The relevant accounts from all doctors and the Hospital Account (first 4 pages only):**

Although we can get most of this detail from the above medical scheme remittance, there are certain other necessary details that we can only obtain from the actual accounts of the service providers.

- **Medical scheme membership certificate:**

A membership certificate is required to ensure that we have on record all the beneficiaries registered under your medical scheme and we also know when you joined the medical scheme. Sometimes these details change and members may have informed their medical scheme but have not advised us of the changes.

- **Hospital Account:**

The hospital account (first 2-3 pages only). NB - if your claim only relates to shortfall from a surgeon/ anaesthetist, then we do not need this account..

Please take note that on receipt of your claim you will receive an email and sms notification confirming receipt of your claim as well as updates regarding the status of your claim. The Claims process will take 7 working days upon receipt of all relevant documents required. Once your claim has been approved, funds will be paid into your personal bank account via EFT. You are required to settle any outstanding accounts directly with your doctor.

If you have any queries please feel free to get in touch with us for clarification.

Claim Form

Please complete in full and sign the declaration below

Personal Details of Principal Member

(This must be the Sanlam Gap principal member)

Surname: _____ First Name: _____
ID Number: _____ Telephone: _____
Cell Phone: _____ e-mail: _____
Employer Name: _____ Branch Name: _____
Date of Employment: _____ Medical Scheme: _____
Membership Number: _____ Name of current Benefit Option: _____
Sanlam reality Member: Yes No Sanlam Reality Number _____

Details of Patient & Service Providers

Patient's Surname: _____ First Name: _____
ID Number: _____ Hospital Admitted to: _____
Admission Date: _____ Discharge Date: _____
Nature of Illness or Condition: _____
Procedure Performed: _____
Name of Surgeon: _____ Practice No: _____

Reimbursement Details

(Principal Member's Account Only)

Bank Name: _____ Branch Code: _____
Account Number: _____ Account Name: _____
Branch Name: _____

Declaration by Principal Member

I hereby declare that the details above as well as any supporting documentation supplied with this claim are true and correct and I am aware that any non-disclosure or false representation may result in the rejection of this claim and/or cancellation of cover.

Full Name:

Signature:

Date: