

Gap Cover Series Claim form

Underwritten by Constantia Insurance Company Limited (CICL), Reg. No. 1952/001514/06, FSP No: 31111 (The Insurer)

This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership. The master policy issued is the source of all benefits, rights, and obligations and exclusions. To determine your individual needs, we suggest that you contact your broker and request advice from him / her.

Claiming procedures

Claims should be submitted in writing by no later than one hundred and eighty (180) days/six months (6) from the first day of treatment to; (i.e. complete the claim form as soon as possible).

Ambledown Financial Services (Pty) Ltd, PO Box 1862, Cramerview, 2060
Tel: 086 126 2533
Fax: 011 463 1665
Email: claims@ambledown.co.za

BEFORE ANY CLAIM CAN BE SETTLED, COPIES OF THE FOLLOWING DOCUMENTATION RELATING TO THIS PARTICULAR CLAIM/S ARE REQUIRED:

1. Hospital Accounts
2. Doctors' Accounts
3. Medical Aid Statement

(Failure to provide all applicable documentation to this claim form will cause undue delay in the processing thereof)

Principal insured member details

Applicant

Title											Surname																					
ID / passport number																						First names										
Date of birth	D	D	M	M	Y	Y	Y	Y																								
Policy / Member number																																

Contact details

Postal address										Physical address (if different to postal)										
Postal code										Postal code										
Home number	Area code									Employer										
Cell number	Area code									Employer contact number	Area code									
Email																				

Family doctor (GP) details

Name																			
Telephone number	Area code																		

Patient details

First names											Male		Female					
Surname											Relationship to principal member:							
ID / passport number										Self	<input type="checkbox"/>	Spouse	<input type="checkbox"/>	Child	<input type="checkbox"/>	Other	<input type="checkbox"/>	
Date of birth	D	D	M	M	Y	Y	Y	Y		Medical scheme name								
Medical scheme options								Scheme number										
Is the claim in respect of a dependent child over 21 years of age?														Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Reason for hospitalisation																		
When did the patient first receive treatment and/ or advice in the above regard?										D	D	M	M	Y	Y	Y	Y	

NOTE: ONLY APPLICABLE TO POLICIES WITH THE DREAD DISEASE / SEVERE ILLNESS BENEFIT

Details of hospital admissions

										Was hospitalisation a result of an accident/ injury?				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>					
Hospital Name	Practice number			Ward type			Date admitted				Date discharged											
							D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
							D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
							D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y

Family doctor (GP) details

Name	Practice number	Date of service								Telephone number					
		D	D	M	M	Y	Y	Y	Y	Area code					
		D	D	M	M	Y	Y	Y	Y	Area code					
		D	D	M	M	Y	Y	Y	Y	Area code					
		D	D	M	M	Y	Y	Y	Y	Area code					
		D	D	M	M	Y	Y	Y	Y	Area code					

Payment instructions

Should benefits be paid into the bank account from which your policy premiums are collected? Yes No

Benefits to be paid into the following bank account by means of electronic fund transfer:

Account holders name		Bank / building society	
Account number		Branch	
Branch code		Account type (No credit card accounts accepted)	Current
			Transmission
			Savings
Are the benefits being paid into the bank account of a person/entity that is not an insured person on the policy?			Yes <input type="checkbox"/> No <input type="checkbox"/>

If yes, state the relationship

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SIGNATURE OF ACCOUNT HOLDER

SIGNATURE OF PRINCIPLE
INSURED MEMBER
(if different from account holder)

DATE

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

Declaration and mandate

I declare that the above particulars are true in every respect and I attach or will forward as soon as possible copies of all hospital, medical accounts and relevant medical aid statements. I hereby authorise any hospital, physician, medical aid or other person who has attended to or examined me or my dependants, to furnish to the company or its authorised representative any information with respect to any illness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital or medical records.

You hereby authorise and mandate us to obtain all necessary information from your Medical Scheme, including but not limited to biographical information, benefit and claim information, and medical information.

You hereby authorise us to negotiate with and request your Medical Scheme to re-assess your claims, negotiate any discount with the relevant Service Providers on your behalf, pay the benefit payable in terms of the Gap Cover Policy directly to the Service Provider, should a discount be negotiated.

If the benefit available to the Insured Person is greater than the fee charged by the Service Provider, then we will pay the balance of the benefit payable in terms of the Gap Cover Policy to the Insured Person once the Service Provider is paid.

This consent and mandate will remain in force until withdrawn in writing.

Except to the extent that we acted with gross negligence or fraudulent intent, you hereby indemnify us and undertake to hold us harmless against any loss, damage, legal liability, legal costs (including costs on an attorney and client scale) or expenses of whatever nature we may suffer or become liable for alleged to arise or arising from the consent and mandate you provided to us in accordance with this Agreement.

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SIGNATURE OF THE INSURED PERSON

SIGNATURE OF PATIENT
(if different from the principal insured)

DATE

D	D	M	M	Y	Y	Y	Y
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(If the patient is a minor, the form must be signed by the parent or guardian, who confirms that they are the competent and authorised person to sign on behalf of the minor)

In case of minor:

Name of the competent and authorised person	
Relationship to the minor patient	

Broker details

Broker name																	
Telephone number	Area code															Email	

Please return to your broker or alternatively: Ambledown Financial Services (Pty) Ltd, PO Box 1862, Cramerview, 2060

Tel Number 0861 262533, Fax Number 011 463 1600, E-mail Address: admin@ambledown.co.za