CLAIM APPLICATION FORM (for claims that take place during 2020)

Contact us

Tel: 0860 102 936, Email: claims@medgaponline.co.za, Facsimile: 011 263 1419

What you must do

SUBMIT YOUR CLAIM TO US WITHIN 180 DAYS OF YOUR CLAIM EVENT OR WE WILL REJECT YOUR CLAIM

1. Fill in and sign the form.
2. Ensure that each section that is relevant to your claim is completed clearly, accurately and completely.
3. Email the form **with all required documents** to claims@medgaponline.co.za.
4. If you are not able to email your claim to us, print your completed claim form and posit it, with all required documents to:

   The MedGap Claims Team, Guardrisk Insurance Company Limited, PO Box 786015, Sandton, 2146.
5. If any details are missing or we need more information or documents, we will contact you. If we do this, please send us the outstanding documents within 28 days of our request or we will close your claim until you provide us with the documents we need. If you do not send us these documents within 12 months of your claim event, your claim will prescribe and we will close it permanently.

TELL US WHO IS COMPLETING THIS FORM

Claimant / Patient	Yes	No	Please read and initial each declaration under Claimant / Patient declaration and consent
Appointed Broker	Yes	No	Please read and initial each declaration under Broker declaration and consent

MAIN MEMBER'S DETAILS

Member/Policy No													Surname							
First name																				
Identity No													Date of birth	d	d	m	m	y	y	y	y
Medical aid name													Plan option								
Medical aid No													Mobile No								
Email address																				

BENEFIT BEING CLAIMED *(PLEASE TICK THE RELEVANT BOXES AND COMPLETE THE RELEVANT SECTIONS)*

Reason for your claim		Benefit being claimed	What to complete
SECTION A: Medical Expense Shortfall Benefits **(Under this section, a maximum of R165 000 can be paid per Insured Person per policy year)**			
Your medical practitioner charged you more for an authorised procedure, than your medical scheme paid and there is a shortfall which you have to pay	☐	Shortfall in medical practitioner costs	Complete Part 1
Your medical scheme applied a co-payment to your medical procedure	☐	Co-payment	Complete Part 2
Your medical scheme has only paid a portion of your oncology treatment and you are liable to pay the difference	☐	Oncology co-payment	Complete Part 3
You have reached your medical scheme's oncology treatment limit and you are liable for all oncology treatment costs for the rest of this year	☐	Oncology extender	Complete Part 4
Your medical scheme applied a rand amount limit to your internal prosthesis and you are liable to pay the difference	☐	Shortfall in internal prosthesis costs	Complete Part 5
You are claiming for a casualty event where emergency treatment was required	☐	Accidental Emergency casualty	Complete Part 6

Medgap cover policy

GUARDRISK TAILORED RISK SOLUTIONS

SECTION B: Lump Sum Benefits

You have been diagnosed with cancer for the first time since your cover started	☐	Lump sum cancer	Complete Part 7
You are claiming for accidental death or permanent and total disability of the principal insured, spouse or dependant	☐	Accidental death / disability / violent crime	Complete Part 8
You are claiming for the premium waiver benefit for accidental death or permanent and total disability of the premium payer, also covered on this policy	☐	Premium Waiver	Complete part 9
You are claiming for the consultation fee charged by your registered counsellor, due to a traumatic event that occurred	☐	Trauma counselling	Complete Part 10
You are claiming for the lump sum benefit on medical confirmation of your pregnancy	☐	Baby Bump Benefit	Complete part 11

PATIENT'S DETAILS

The patient must be named on your cover with us and must be covered on your medical aid at the time of a claimable event.

First name	Surname	Relationship	Identity number

Medical condition treated:

Date when symptoms first began: d d m m y y y y

Did the symptoms begin before cover started? Yes ☐ No ☐

Patient's Height (m):	_____m
Patient's Weight (kg):	_____kg

Does the patient know their BMI? (Body Mass Index)	Yes
	No

Would the patient consider their BMI to be:	Above normal range (>25)	
	In normal range (18.5 – 24.9)	
	Below normal range (<18.4)	

Important to note:

- **Any cancer, birth or pregnancy-related medical condition that existed within 12 months before the first day of cover will be excluded for 12 months after cover starts; and**
- **Any other physical defect, medical condition, illness or injury that existed within 12 months before the first day of cover will be excluded for 9 months after cover starts.**
- **The above applies independently to each person named on your cover.**

Failure to disclose pre-existing medical conditions on application for cover could limit and/or exclude certain benefits or result in the termination of your cover.

BANKING DETAILS OF THE PRINCIPAL MEMBER

Account holder name		Bank name	
Branch name		Branch code	
Account number			

Type of account: Cheque ☐ Savings ☐ Transmission ☐

Medgap cover policy

GUARDRISK TAILORED RISK SOLUTIONS

PART 1 – SHORTFALL IN MEDICAL PRACTITIONER COSTS

This benefit pays up to 3 times the amount paid by your medical aid for each service undertaken by the practitioner.

We process your claim on a line-by-line level according to your medical practitioner's account and some of these charges may not be covered. This means that we may not pay your claimed shortfall in full.

Exclusions to this benefit include (but are not limited to) hospital and day clinic fees and ward/theatre charges, medication and materials, appliances and fees related to BMI, obesity or body weight.

This procedure was: In hospital ☐ Out of hospital ☐ As a result of an accident: Yes ☐ No ☐

Date admitted: d d m m y y y y Date discharged: d d m m y y y y

Name of hospital / day clinic:

Procedure undertaken:

Date of service	Medical service provider	Total charged	Medical aid paid	Shortfall
d d m m y y y y		R	R	R
d d m m y y y y		R	R	R
d d m m y y y y		R	R	R
d d m m y y y y		R	R	R
			Total shortfall being claimed	R

Supporting documents to be submitted *(please tick that you have attached each of the below documents)*:

Hospital/day-clinic account *(showing* date of admission & *discharge, patient details, diagnosis code and each service)* ☐ Doctor account *(for each doctor being claimed)* ☐ Medical aid statement *(showing each service for each doctor being claimed)* ☐

Please note that an online claims history or summary does not provide sufficient information – we need the complete PDF claim statement from your medical aid.

PART 2 – CO-PAYMENT

This benefit pays for certain co-payments that have been applied by your medical aid.

Exclusions to this benefit include (but are not limited to) co-payments that are for using a non-designated service provider, that relate to the use of a private ward and that apply to any procedure or condition in a waiting period.

Co-payment was applied to: In-network hospital ☐ Out-of-network hospital ☐ As a result of an accident Yes ☐ No ☐

Name of hospital / day clinic:

Date admitted: d d m m y y y y Date discharged: d d m m y y y y

Date of service	Medical service provider	Co-payment
d d m m y y y y		R
d d m m y y y y		R
	Total	R

Supporting documents to be submitted *(please tick that you have attached each of the below documents)*:

Pre-authorisation letter *(reflecting co-payment applied) or detailed medical aid statement (reflecting co-payment applied)* ☐ Proof of payment ☐ Hospital account *(showing co-pay charged, date of admission & discharge, patient details, diagnosis code & services)* ☐

PART 3 – ONCOLOGY CO-PAYMENT

This benefit pays out up to 20% of co-payments applied by your medical aid once the annual oncology treatment limit has been reached.

Exclusions to this benefit include (but are not limited to) treatment undertaken by a non-designated service provider.

This is the 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ oncology co-payment claimed this year

Date of treatment	Medical service provider	Total charged	Medical aid paid	Shortfall
d d m m y y y y		R	R	R
d d m m y y y y		R	R	R
d d m m y y y y		R	R	R
		Total co-payments		R

Supporting documents to be submitted *(please tick that you have attached each of the below documents)*:

Test results (1st claim only) ☐ Histology report (1st claim only ☐ Oncology treatment plan (1st claim only) ☐ Annexure B (1st claim only) ☐ Med. aid statement (each claim) ☐ Service provider acc. (each claim) ☐

PART 4 – ONCOLOGY EXTENDER

This benefit pays out up to 20% of oncology treatment costs incurred once the annual oncology treatment limit on your medical aid has been reached.

Exclusions to this benefit include (but are not limited to) treatment undertaken by a non-designated service provider.

This is the 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ oncology extender benefit claimed this year

Date of treatment	Medical service provider	Total charged
d d m m y y y y		R
d d m m y y y y		R
d d m m y y y y		R
	Total treatment costs	R

Supporting documents to be submitted *(please tick that you have attached each of the below documents)*:

Test results (1st claim only) ☐ Histology report (1st claim only ☐ Oncology treatment plan (1st claim only) ☐ Annexure B (1st claim only) ☐ Med. aid statement (each claim) ☐ Service provider acc. (each claim) ☐

PART 5 – SHORTFALL IN INTERNAL PROSTHESIS COSTS

This benefit pays for shortfalls in the cost of an internal prosthesis which replaces a body part. The maximum benefit payable under this benefit is R30 000 per policy per year.

Exclusions to this benefit include (but are not limited to) devices that assist with the functioning of a body part (e.g. pacemaker, stent, etc.) and external prosthesis or dental implants.

Date admitted: d d m m y y y y Date discharged: d d m m y y y y

Name of hospital / day clinic:

Date of service	Medical service provider	Total charged	Medical aid paid	Shortfall
d d m m y y y y		R	R	R
d d m m y y y y		R	R	R
			Total shortfall being claimed	R

Supporting documents to be submitted *(please tick that you have attached each of the below documents)*:

Hospital account *(showing* date of admission & *discharge, patient details, diagnosis code and each service)* ☐ Medical aid statement *(reflecting the prosthesis shortfall)* ☐

PART 6 – ACCIDENTAL EMERGENCY CASUALTY

This benefit will pay up to R10 000 of casualty ward costs incurred. This benefit is limited to 3 casualty visits per family per year, as long as each visit is both an accident and an emergency.

1 of these casualty ward visits may be due to an Emergency only, for a dependent that is five (5) years old or less on the date of the claim event. The benefit for this claim will be limited to R2 000 and it will accumulate to your three (3) claim events and R10 000 benefit limit per year.

Exclusions to this benefit include (but are not limited to) elective procedures undertaken in casualty and casualty ward visits due to illness, except for 1 visit for a dependant 5 years and younger.

Date of casualty visit: d d m m y y y y

Time of casualty visit h h : m m

This is the 1st ☐ 2nd ☐ 3rd ☐ casualty visit for this year **or** 1 visit for your dependant child under 5 ☐

Date of birth of child:: d d m m y y y y When claiming for an emergency visit for your dependent child under 5

Name of medical facility:

Give full details of circumstances leading to the claim event as well as details of the injury

Date of treatment	Medical service provider	Total charged	Medical aid paid	Shortfall
d d m m y y y y		R	R	R
d d m m y y y y		R	R	R
d d m m y y y y		R	R	R
d d m m y y y y		R	R	R
d d m m y y y y		R	R	R
		Total shortfall being claimed		R

Supporting documents to be submitted *(please tick that you have attached each of the below documents)*:

Casualty admission form ☐ Casualty account ☐ Medical aid statement *(showing amounts paid by the medical aid)* ☐

PART 7 – LUMP SUM CANCER

If diagnosed with minimum stage II, local and malignant cancer for the first time, we will pay you a once-off lump sum benefit of R5 000. If however, you are diagnosed with minimum stage II, regional and malignant cancer for the first time, we will pay you a once-off lump sum benefit of R15 000.

In addition, if you are successful in claiming the R15 000 benefit and the extent of treatment that you need results in your medical scheme paying R200 000 or more for your oncology treatment within your first one-year treatment cycle, we will pay you a further R10 000.

Exclusions to this benefit include (but are not limited to) all skin cancers and all cancers diagnosed and treated by primary biopsy only, where it does not require further surgical, medical or radiotherapy.

Which benefit are you claiming? 1st lump sum of R15 000 ☐ 2nd lump sum of R10 000 ☐

Date of diagnosis d d m m y y y y Is this the first diagnosis of cancer? Yes ☐ No ☐

Supporting documents to be submitted *(please tick that you have attached each of the below documents)*:

Test results ☐ Histology report ☐ Oncology treatment plan ☐ Annexure B ☐ Medical aid statement ☐

PART8 – LUMP SUM FOR ACCIDENTAL DEATH / PERMANENT TOTAL DISABILITY / VIOLENT CRIME BENEFIT

This benefit pays out a lump sum of R50 000 in the event of accidental death or permanent and total disablement of an insured life. The accidental death benefit is limited to R10 000 for minors between the age of 0 and 5 years, and R30 000 between the age of 6 and 13 years.

If death or permanent and total disability is the result of a violent crime we will double the benefit amount paid out. The maximum death benefit pay-out for children is capped by legislation.

Exclusions to this benefit include (but are not limited to) claim events that are NOT due to an accident.

Date of accident/incident	d	d	m	m	y	y	y	y

Was the death or permanent and total disability due to a violent crime:	Yes	No

Benefit being claimed: Death ☐ Disability ☐

Give details of circumstances leading to the claim event:

Supporting documents to be submitted *(please tick that you have attached each of the below documents)*:

Death certificate (if death) ☐ Accident report (if death or disability) ☐ Annexure A (if disability) ☐ Police report ☐ Case Number ☐

PART 10 – PREMIUM WAIVER BENEFIT

If you or a dependant who pays the monthly premium due on this policy, dies or become Permanently and Totally Disabled as a result of an Accident while covered under this policy, we will assist your dependants in covering the cost of their monthly medical scheme contributions and gap cover premium by paying them the equivalent of R5 000 per month for 6 months.

The full amount of R30 000 however, will be paid when processing the claim, and not in instalments over the 6-month period.

Exclusions to this benefit include (but are not limited to) Death or Disability that is not due to an Accident as defined in the policy

Date of accident/incident	d	d	m	m	y	y	y	y

Benefit is being claimed due to : Death ☐ Disability ☐

Is the Insured the premium payer on this policy:	Yes	No

Give details of circumstances leading to the claim event:

Supporting documents to be submitted *(please tick that you have attached each of the below documents)*:

Death certificate (if death) ☐ Accident report (if death or disability) ☐ Annexure A (if disability) ☐

PART 9 – TRAUMA COUNSELLING

This benefit pays R750 per counselling session and up to R25 000 per year for trauma due to being a victim of, or a witness to, an act of violence or a traumatic accident.

Exclusions to this benefit include (but are not limited to) counselling that is not related to an act of violence or a traumatic accident.

Date of claim event	d d m m y y y y	3rd Counselling session	d d m m y y y y
1st Counselling session	d d m m y y y y	4th Counselling session	d d m m y y y y
2nd Counselling session	d d m m y y y y	5th Counselling session	d d m m y y y y

Give details of the claim event that lead to the counselling session/s	

Supporting documents to be submitted *(please tick that you have attached each of the below documents)*:

Counsellor account ☐ Proof of payment ☐ Accident report ☐ Police report ☐

+

PART 10 – BABY BUMP BENEFIT

If you are diagnosed as pregnant by your Medical Practitioner while covered on the policy, we will pay you a fixed amount of R2 000 to assist you with unexpected pregnancy costs.

Exclusions to this benefit include (but are not limited to) any pregnancy diagnosis which occurs before your cover with us begins

.

Date of pregnancy diagnosis: d d m m y y y y

Supporting documents to be submitted *(please tick that you have attached each of the below documents)*:

Quantitive (beta hCG) Test results ☐ **or** Proof of registration on medical scheme's maternity programme ☐

BROKER DECLARATION AND CONSENT – only applicable when broker is completing claim form on behalf of claimant/patient

Please initial each of the following sentences below to confirm that you are in agreement with the statement:

1. The claimant/patient has authorised you to complete this claim form on their behalf and you confirm that the information provided is true and accurate as advised by your client. ☐
2. You can provide proof of your client's above mentioned authorisation timeously on request by Guardrisk. ☐
3. You declare that you have read the below Claimant / Patient declaration and that your client is aware of each declaration you are signing on their behalf. ☐

Date signed: d d m m y y y y

_____

Signature of Broker

CLAIMANT / PATIENT DECLARATION

Please initial each of the following sentences below to confirm that you are in agreement with the statement:

1. You declare that the above and attached information is true, that you have withheld no material information and that all relevant required documentation is attached to this claim form ☐
2. You confirm your understanding that if this claim form is incomplete or you have not submitted all required supporting documentation, Guardrisk may not process your claim ☐
3. You confirm your understanding that should any material information be withheld or incorrectly furnished during the claim process, Guardrisk may cancel your cover and premiums paid may be used to offset expenses incurred by Guardrisk ☐
4. You authorise Guardrisk to make claim payments to the account nominated in this form ☐
5. You undertake to inform Guardrisk of any change in your banking details and you authorise Guardrisk to verify such banking details with your bank ☐
6. You confirm that Guardrisk shall not be held liable for incorrect claim payments made as a result of your failure to inform Guardrisk of any change in banking details ☐
7. You accept and understand that you are limiting your right to privacy. You authorise Guardrisk to obtain from any person, other insurer, medical scheme, medical practitioner/institution, any information that Guardrisk to facilitate the processing of this claim. You authorise such person(s) to give the said information to Guardrisk, and to share with other insurers and medical schemes any information in this claim form, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Guardrisk or the operators of such database may decide from time to time ☐
8. You authorise the disclosure of relevant medical information by your medical scheme to Guardrisk to assist in the processing of claims under this policy. This information could include your (or one of your dependants') diagnosis, treatment and medical history. ☐
9. You further confirm that your dependants and/or beneficiaries have also provided the necessary authority for your medical scheme to disclose their relevant medical information to Guardrisk to assist in the processing of claims under this policy. ☐
10. You authorise Guardrisk to negotiate on your behalf with your medical scheme in respect of shortfall claims that may have arisen from medical events which your medical aid is legally obliged to cover in full (Prescribed Minimum Benefits). ☐
11. You authorise Guardrisk to negotiate discounts on your and your dependants' behalf with medical service providers in order to maintain a good risk profile for your cover. If successful, you acknowledge that payment will be made directly to the service provider's bank account and no further payment will be due to you. ☐
12. I authorise Guardrisk to disclose all relevant information to the appointed broker on my policy to assist in the processing of this claim. This information could include my (or one of my dependants') medical diagnosis, treatment and history as well as personal information. I further confirm that my dependants and/or beneficiaries have also provided the necessary authority to disclose their relevant information to the appointed broker to assist in the processing of any claims processed by Guardrisk on this policy. ☐

_____ _____

Signature Date

ANNEXURE A

DISABILITY REPORT FOR ACCIDENTAL PERMANENT AND TOTAL DISABILITY

(Required for lump sum permanent and total disability benefit claims)

To be completed by the claimant's attending Medical Practitioner only

Full names of claimant						
When were you first consulted by the claimant in connection with his/her injuries?			Are you still in attendance?		Yes	No
In your opinion, was the disability due to an accident?	Yes	No	Is the claimant permanently and total disabled from attending to any portion of his/her usual business or occupation?		Yes	No
What was the cause of the accident?						
What injuries were sustained?						
Please state the exact cause and nature of the disability						
Does the present disability relate in any way to previous injuries or pre-existing conditions or illnesses?	Yes	No	If yes, please provide detail			
Is the claimant now or was he/she at the time of the accident subject to, or suffering from, any illness or disease irrespective of the accident for which the benefit is claimed?	Yes	No	If yes, state the nature and to what extent the recovery of the claimant may be affected thereby?			
Please state any information not already mentioned which is relevant to the assessment of any permanent disability arising from the accident						
Based on your assessment, do you think the claimant will recover fully or partially?	Yes	No	If yes, please provide reasons			

Medical Practitioner Declaration

I hereby certify that the above statements are true in every respect.	
Name	
Qualifications	
Physical Address:	
Telephone No:	
Email address:	
Practice No.	

_____ _____

Signature Date

ANNEXURE B

ONCOLOGY MEDICAL REPORT

(Required for lump sum cancer claims, 1st oncology co-payment and 1st time oncology extender claims)

To be completed by the claimant's attending Medical Practitioner only

Full names of claimant				
Is this the claimant's first diagnosis of any type of cancer?	Yes	No	If no, when was the claimant first diagnosed with cancer?	
Please provide details of any previous diagnosis of cancer				
Please provide full details of current diagnosis of cancer				

Please clarify the severity of the current diagnosis by marking the relevant box	Stage			
	1	2	3	4

Please clarify the severity of the current diagnosis by marking the relevant box	Local	or	Regional
Please clarify the severity of the current diagnosis by marking the relevant box	Benign	or	Malignant

Medical Practitioner Declaration

I hereby certify that the above statements are true in every respect.	
Name	
Qualifications	
Physical Address:	
Telephone No:	
Practice No.	

_____ _____

Signature Date