



## **Claim Form**

## Important note

Please complete, sign and return the Claim Form to: Gapinfo@centriq.co.za

- 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.
- You have six months from the last day that you were hospitalised to submit your Claim and relevant supporting documentation. Any Claim received for the first time after the six month period has expired, may not be honoured.
- Please note that if you are a VAT registered vendor and the loss was incurred in furtherance of your enterprise, this insurance claim settlement could potentially create a liability to pay output VAT to SARS i.t.o. S8 (8) of the VAT Act.
- Claims are assessed on a line by line basis. Each line has a ICD code on your service provider's account that accumulates to the total amount charged. Your medical scheme must pay a portion of the cost per line from your hospital benefit in order for that claim line shortfall to be reviewed by your Gap cover.
- Claims flagged as Prescribed Minimum Benefit (PMB) may be investigated with your medical scheme or discussed with your service provider. PMBs are a set of defined benefits that medical schemes are required to cover by law. This means that as a medical scheme member, you shouldn't incur any out-of-pocket medical expenses related to a PMB.
- Processing of insurance information is done in accordance with applicable legislation, as well as our Privacy Policy which can be found in our Compliance and Trust Centre: www.centriq.co.za.
- When submitting the Claim form, you will need to provide supporting documents as detailed below in the checklist. Claims can be emailed to **Gapinfo@centriq.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 direct all queries to the Sanlam Gap Service Centre on **0861 111 167**. To view, visit the **Sanlam Gap Claim Journey**.

## In order for us to assess your Claim without any delays, please ensure you submit the following documents:

Claims Checklist	Tarriff Shortfalls, Sub- limits, Co-Payments, Accidental Casualty & Child illness Where to get it?	Shortfalls & Co-Payments Accidental Casualty & Child Illness	Family Booster	Hospital Booster	Family Protector	Contribution Waiver	Mediclinic Extender & Oncology Lump Sum
Sections to complete		A - E & J	A - D, H & J	A - D, G & J	A - C, F & J	A - C, F & J	A - D, I & J
Claim form		<b>⊘</b>	<b>⊘</b>	<b>⊘</b>	<b>⊘</b>	<b>⊘</b>	<b>⊘</b>
Hospital account (not statement)	Hospital	Ø		<b>⊘</b>			
Doctor account (not quote)	Doctor's Practice	<b>⊘</b>					
Medical scheme statement (Including rejection reasons)	Medical Scheme	<b>⊘</b>					
Death certificate	Home Affairs					Ø	
Accident report (if reported to SAPS)	SAPS					<b>⊘</b>	
Letter confirming expected vs actual delivery date	Medical Doctor/ Doctor's Practice		<b>⊘</b>				
Medical Report confirming Cancer diagnosis and date of Diagnosis from stage 2 or higher	Oncologist / Pathologist						<b>⊘</b>



A. Policyholder Details						
Title: Name:	Surname:					
ID No. (compulsory field):	Date of Birth: YYYYMM DD					
Cellphone No.:	Alternative Contact No:					
Physical/Postal Address:						
	Postal Code:					
Email Address:	Medical Scheme:					
Membership No.:	Medical Scheme Plan:					
B. Payment Instructions						
Payments will only be made to the Policyholder's account.						
No payments will be made to credit card accounts.						
The company will not be liable for the loss of funds due to the provision	on of incorrect bank details by the Policyholder.					
Account Name:	Account Number:					
Bank: Account Type:	Branch Code:					
Account Holder Signature:						
C. Patient Details						
Relationship to Policyholder: Self Spouse Child Other:						
Do not complete this section if the Patient is the Policyholder.						
Title: Full Name:						
ID Number:						
D. Event Details						
If you are claiming for the Medical Scheme Contribution Waiver and Far	mily Protector Benefits, please do not complete this section.					
Where did the procedure take place: In-Hospital Doc	tors Rooms Casualty Ward					
Reason for treatment: Accident Oncology	Illness / Surgery					
Hospital/Service Provider Name:						
Reason for Hospitalisation/Treatment:						
Admission/event date: YYYY MM DD Discharge date: YYYY MM DD						
If this event was related to Oncology Treatment, please confirm the date you were first diagnosed:						



E. Benefit Cla	aimed   Medical Sc	heme Tarriff	Shortfalls and	d Co-Paymen	ts:	
Service Date	Service Provider	Charged Amount	Medical Scheme Paid	Shortfall you are Claiming	Have you paid the Service Provider	
					Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	
Event Deta	ails   Medical Sche	me Contribu	ition Waiver ai	nd Family Pro	tector:	
elect the benefit y	rou are claiming for:	1edical Scheme C	ontribution Waiver	Family F	Protector	
Was the Death or Disability due to an accident? Yes No Only accidents are covered						
eate of Death/Accid					embership Certificate	
vetails leading to di		Please	инаста сору от те	Triedical Scheille M		
ledical Scheme Pre			(Amount in Rands	-1		
	emium: y of the Death Certificate a	and Police Report	<b>3</b> '	o)		
	,	, 				
3. Event Deta	ails   Mental Health	Benefit:				
Admission Date	Discharge Date		Reason for	Hospital Episode		
H. Event Deta	ails   Hospital Boos	ster:				
Admission Date Discharge Date Reason for Hospital Episode						
. Event Deta	ails   Family Booste	er:				
	Due Date			Birth Date		
			•			
I. Event Deta	ails I Sanlam Gap C	Comprehens	ive Oncology	Lump Sum Be	enefit:	
Diagnosis [	Date	Tv	oe of Cancer		Is this a first	
— Diagnosis L		T y	of Sancer		time diagnosis	
					Yes No	
					Yes No	
C. Event Deta	ails   Mediclinic Ext	tender Onco	logy Lump Su	m Benefit		
	•				Is this a first	
Diagnosis [	Date	Ту	oe of Cancer		time diagnosis	
					Yes No	
					Yes No	



L. Declaration							
I, (full name) with ID number							
declare that the information, including all supporting documentation, provided to Centriq the insurer in support of my claim is true and correct. I understand that any non-disclosure or false information my result in my claim not being paid or the cancellation of my cover.							
I hereby authorise my medical scheme and healthcare providers, where applicable, to provide Centriq the insurer or their authorised representative with any information they may need to assess my claim.							
Centriq the insurer reserves the right to negotiate a discounted rate with the relevant service providers on your behalf, if a discount is granted, payment will be made directly into the respective service provider's/Doctor's bank account thus							
rendering the Payment Instruction on the Claim Form null and void.							
Full Name: Signature:							
Date: YYYYMM DD							
POPIA Consent							
Use of Personal Information Declaration							
I consent to Centriq Insurance, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract. For further information please read our Privacy Notice, which can be found on www.centriq.co.za							
May we contact you for marketing purposes, for example, when we run competitions or launch new products?							
Yes No							
How may we contact you?  Email SMS/WhatsApp Telephone only All methods							
Please return the completed claim form to:							
E-mail address: Gapinfo@centriq.co.za							

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.

AfroCentric Health (RF) (Pty) Ltd holds preference shares in Centriq Insurance Company Limited. Insurance Products are insured by Centriq Insurance Company Limited ("Centriq") a licensed non-life insurer and authorised Financial Services Provider (FSP 3417).

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0861 111 167

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