# GAP SHIELD CLAIM APPLICATION FORM 2022 (for claims that take place during 2022)

**Contact us**

Tel: 0860 102 936, Email: **gapshield@guardrisk.co.za**, Facsimile: 011 263 1419

**What you must do**

**SUBMIT YOUR CLAIM TO US WITHIN 180 DAYS OF YOUR CLAIM EVENT OR WE MAY 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 **admed@guardrisk.co.za.**
4. If you are not able to email your claim to us, print your completed claim form and fax it to 011 263 1419, alternatively, you can post it, with all required documents to:

   **The Admed Gap Shield 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 scheme name | | | | | | | | | | | | | | Plan option | | | | | | | | |
| Medical scheme No | | | | | | | | | | | | | | Mobile No | | | | | | | | |
| Email address | | | | | | | | | | | | | | | | | | | | |

## 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 | | | |
| Details of 1st doctor consulted | Name: | | | | | | | | Tel 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) | |

## BANKING DETAILS - We can only pay claim refunds into the principal member's bank account

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Account holder name | | | | | | | | | | | | | | Bank name | | | | | | | | | | | |
| Branch name | | | | | | | | | | | | | | Branch code | | | | | | | | | | | |
| Account number | | | | | | | | | | | | | | | | | | | | | | | | | |

Type of account: Cheque ☐ Savings ☐ Transmission ☐

## SHORTFALL IN MEDICAL PRACTITIONER COSTS

**This benefit pays up to 3 times the amount paid by your medical scheme 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 ☐

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 scheme 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 scheme statement** *(showing each service for each doctor being claimed)* ☐

**Please note that an online/email claims history or summary from the scheme does not provide sufficient information –**
**we need the complete PDF claim statement from your medical aid, this is usually sent to you on a monthly basis.**

## 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