

# Gap Cover Series Claim form

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

Please check that you have met the waiting period before submitting your claim. Accidents are covered immediately after your 1<sup>st</sup> successful payment. Other procedures are covered after 3 successful payments. You have a 12 month waiting period for any incident or illness for which you received treatment or advice within 12 months prior to being covered under this policy.

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
4. Proof of bank details (only applicable if this is your first time claiming)

You can download the g-App on your mobile phone to submit and track your claim, quick and easy.  
(Failure to provide all applicable documentation to this claim form will cause undue delay in the processing thereof)



## Principal insured member details

### Claimant

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																	

# THE UNLIMITED



## Patient details

First names: \_\_\_\_\_ Male  Female

Surname: \_\_\_\_\_ Relationship to principal member:  
Self  Spouse  Child  Other

ID/passport number: \_\_\_\_\_

Date of birth: 

D	D	M	M	Y	Y	Y	Y
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 Medical scheme name: \_\_\_\_\_

Medical scheme options: \_\_\_\_\_ Scheme number: \_\_\_\_\_

Is the claim in respect of a dependent child over 21 years of age? Yes  No

Reason for hospitalisation: \_\_\_\_\_

When did the patient first receive treatment and/or advice in the above regard? \_\_\_\_\_

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  No

Hospital Name	Practice number	Ward type	Date admitted	Date discharged																
_____	_____	_____	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
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D	D	M	M	Y	Y	Y	Y													
D	D	M	M	Y	Y	Y	Y													



## Providers/Doctors details

Name	Practice number	Date of service	Telephone number								
_____	_____	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	Area code _____
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D	D	M	M	Y	Y	Y	Y				



## 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 holder's name:	Bank/building society:
Account number:	Branch:
Branch code:	Account type:
Source of funds:	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  No

If yes, state the relationship: \_\_\_\_\_

SIGNATURE OF ACCOUNT HOLDER

SIGNATURE OF PRINCIPAL 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

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.

I consent to Ambledown or any authorised 3<sup>rd</sup> party from obtaining and processing my (or my dependents) personal information and I understand why my/their personal information is required and the purpose it will be used.

This consent and mandate will remain in force until withdrawn in writing. I acknowledge I have the right to request from Ambledown details of any of my personal information Ambledown holds on my behalf and details of how my personal information has been processed and to lodge a complaint with the Information Regulator.

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 member)

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:

Please return to The Unlimited or alternatively:

Ambledown Financial Services (Pty) Ltd, PO Box 1862, Cramerview, 2060

Tel Number: 0861 262 533, Fax Number: 011 463 1600, Email Address: claims@ambledown.co.za

The Unlimited

FSP number: 21473

0861 990 000, www.theunlimited.co.za

Your benefits are underwritten by Guardrisk Insurance Company Limited. Guardrisk Insurance Company Limited is an authorised financial services provider and licensed non-life insurer (FSP 75).