ambledown
FINANCIAL SERVICES (PTY) LTD

GAP COVER SERIES CLAIM FORM

Underwritten by Hollard Group Risk (HGR), a division of The Hollard Insurance Company Limited, Reg. No. 1952/003004/06, FSP No: 17698 (The Insurer)

Claiming Procedures

Claims should be submitted in writing (by no later than one hundred and eighty (180) days/six months (6) from the date of incident (i.e. complete the claim form as soon as possible). Claim forms should be returned either by post, fax or email:

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

Principal Insured Member Details			
Surname:		Initials:	
ID Number:		Policy/ Member No.:	

Contact Details		
Postal Address:	Telephone No.:	
	E-mail Address:	
	Cell phone No.:	
Postal Code:	Work No.:	
Employer:		
Contact No.:	( )	

Family Doctor (GP) Details			
Name:		Telephone No.:	( )

Patient Details									
First Names:				Male		Female			
Surname:		Relationship to the Principal Member							
ID No:		Self		Spouse		Child		Other	
Medical Aid Name		Medical Aid Option		M/Aid No.:					
Is the claim in respect of a dependent child over 21 years of age?		Yes:		No:					
If Yes, please attach details of the School, College or University attended by the patient and/ or proof that the child is totally dependent on the Principal Member.									

Product Selection			
Please indicate (X) which product you are cover with			
Gap Cover		Gap Plus	
Gap Plus Extend		Gap Shield	
Gap Shield & Co-pay		Gap Select	
Gap Seniors		Gap Seniors Plus	

Benefit Category			
Please indicate (X) the benefit the claim is in respect of (You may select more than one category)			
Gap Cover		Co-Payments/Deductibles In-Hospital	
Co-Payments for MRI & CT Scans		Sub-Limitations In-Hospital	
Outpatient diagnostic radiology		Biologic Treatments & Medicines	
Other (please specify)			

Reason for Hospitalisation:	
When did the Patient first receive treatment and/ or advice in the above regard?	

Details of Hospital Admissions:	Was hospitalisation a result of an accident/ injury?	Yes:		No:	
Hospital Name	Practice No.	Ward Type	Date Admitted	Date Discharged	

Providers/ Doctors Details:			
Name	Practice No.	Date of Service	Telephone Number

Payment Instructions												
Benefits to be paid into my bank account by electronic fund transfer, details below:												
Account Holders Name:												
Account Number:												
Bank:												
Branch Name:				Branch Code:								
Account Type:	Current		Savings		Transmission		(No credit card accounts accepted)					
Signature of Account Holder (Principal Insured Member)				Name of Account Holder (Principal Insured Member)								
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 and medical accounts and relevant medical aid statements. I hereby authorise any hospital, physician 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. A copy of this authorisation shall be considered as effective and valid as the original.	
Signature of the Principal Insured Member	Name and Surname of the Principal Insured Member
Date Signed	

Broker Details	
Broker Name & Contact details	

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.)