OLDMUTUAL

9 Queen Street, Durbanville, 7550
PO Box 863, Durbanville, 7551
omclaims@insuremed.co.za

CLAIM FORM
GAP COVER

INSTRUCTIONS

Please complete in full and sign the declaration below.

In order for us to process your claim, we need you to please send the following documents to **omclaims@insuremed.co.za**

1. Copy of the hospital account. (Please contact the hospital for a copy.)
2. Copy of the doctor's account(s). (Please contact the doctor for a copy.)
3. Copy of the medical scheme statement, showing the short-payment.
4. Authorisation confirmation from your medical scheme.
5. Copy of the latest (not older than 3 months) medical scheme membership certificate.
6. Should the bank details for payment of claims differ from the debit order bank details listed on the policy schedule, proof of bank detail must be provided.

IMPORTANT: Claims must be submitted to Old Mutual Gap Cover within 4 months after end of the Covered Event. Claims cannot be processed until all the required documents have been received.

1. PERSONAL DETAILS OF PRINCIPAL MEMBER

Title:		Initials:		Surname:	
ID No:				Policy No:	
Medical Scheme:				Scheme No:	
Benefit Option:					

2. DETAILS OF PATIENT & SERVICE PROVIDERS

Practice Name:		Practice No:		Service Date:	
Patient Name:		Unpaid Amount:			
Practice Name:		Practice No:		Service Date:	
Patient Name:		Unpaid Amount:			
Practice Name:		Practice No:		Service Date:	
Patient Name:		Unpaid Amount:			
Practice Name:		Practice No:		Service Date:	
Patient Name:		Unpaid Amount:			
Practice Name:		Practice No:		Service Date:	
Patient Name:		Unpaid Amount:			

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3. REIMBURSEMENT DETAILS (Principal Member's Account Only)

Account Name:		Bank Name:	
Account No:		Account Type:	

4. DECLARATION BY PRINCIPAL MEMBER

I hereby declare that the details above, as well as any supporting documentation supplied with this claim, are true and correct and I am aware that any non-disclosure or misrepresentation may result in this claim being rejected or my policy being cancelled or voided from inception.

Full Name:		Signature:	
Date:	D D M M 2 0 Y Y		

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