CLAIM FORM

GapCover®
medical shortfall solutions

Email: claims@insuremed.co.za / Fax: 0865 846 343

A PRINCIPAL MEMBER DETAILS

Title: | Initials: | Surname:

ID/Passport No: | Policy No: G A P

Medical Scheme: | Option:

Membership No:

B CLAIM DETAILS

Practice Name	Practice No.	Service Date	Patient Name	Unpaid Amount

All GAPCover and/or CoPay claims must be accompanied by the following documents:

1 Copy of the hospital and doctors account(s). (Please contact the hospital/doctor for a copy.)

2 Copy of the medical scheme statement, showing the short-payment.

3 Authorisation confirmation from your medical scheme.

4 Copy of the latest (not older than 3 months) medical scheme membership certificate.

5 Should the bank details for payment of claims differ from the debit order bank details listed on the policy schedule, proof of bank details must be provided.

NB: Claims must be submitted to GapCover within 3 months after the scheme payment date.
NB: Claims cannot be processed until all the required documents have been received.

C BANKING DETAILS (Claim Refunds)

Account Holder:

Name of Bank: | Branch Code:

Account No: | Account type:

Contact No/s: H | W | C

The administrator does not accept responsibility for payments made to incorrect bank details provided above.

Date: D D M M Y Y Y Y

Signature of account holder:

Underwritten by Western National Insurance Company Limited
Administered by Insuremed Administrators