Sanlam

UNDERWRITTEN BY CENTRIQ INSURANCE

Claim Form

1. Please note that this is not an automatic process, and you will be required to submit a separate Claim form to the Claim that has been submitted to your Medical Scheme.
2. You have six months from the last day that you were hospitalised to submit your Claim and relevant documentation. Any Claim received for the first time after the six month period has expired, will not be honoured.
3. Please note that if you are a VAT registered vendor, this insurance claim settlement could potentially create a liability to pay output VAT to SARS i.t.o. S8 (8) of the VAT Act.
4. Claims are assessed on a line by line basis. Each line has a code on your service provider's account that accumulates to the total amount charged. Your medical aid must pay a portion of the cost per line from your hospital benefit in order for that claim line shortfall to be reviewed by your Gap cover.
5. Claims flagged as Prescribed Minimum Benefit (PMB) may be investigated with your medical aid or discussed with your service provider. PMBs are a set of defined benefits that medical aids are required to cover by law. This means that as a medical aid member, you shouldn't incur any out-of-pocket medical expenses related to a PMB.
6. Processing of insurance information is done in accordance with applicable legislation, as well as our Privacy Policy which can be found in our Compliance and Trust Centre on our website: www.kaelo.co.za and www.centriq.co.za.
7. When submitting the Claim form, you will need to provide supporting documents as detailed below in the checklist. Claims can be emailed to **sanlamclaims@kaelo.co.za**. Once received, your Claim will be processed and if all requirements have been met, the Benefit amount will be paid within 7 to 14 working days. Please direct all queries to the Sanlam Gap Service Centre on **0861 111 167**. Visit **https://www.kaelo.co.za/quick-links/** to view the Claims Journey.

In order for us to assess your Claim without any delays, please ensure you submit the following documents:

Claims Checklist	Where to get it?	Shortfalls & Co-Payments Accidental Casualty & Child Illness	Family Booster	Hospital Booster	Family Protector	Contribution Waiver	Mediclinic Extender & Cancer Lump Sum
Sections to complete		A - E & J	A - D, H & J	A - D, G & J	A - D, F & J	A - D, F & J	A - D, I & J
Claim form		✓	✓	✓	✓	✓	✓
Hospital account *(not statement)*	Hospital	✓		✓			
Doctor account *(not quote)*		✓					
Medical aid statement *(Including rejection reasons)*	Medical Aid	✓					
Death certificate						✓	
Accident report *(if reported to SAPS)*						✓	
Letter confirming expected vs actual delivery date	Medical doctor		✓				
Medical reports	Oncologist						✓
Histology reports	Pathologist or Oncologist						✓
Oncology treatment plan	Medical Aid						✓

Important note

Please complete, sign and return the Claim Form to: sanlamclaims@kaelo.co.za.

A. Policyholder Details

Title: _____ Full Name: _____

ID Number: _____

Medical Scheme Name: _____ Medical Scheme Plan: _____

Medical Scheme No: _____ Gap Policy No: _____

Cell No: _____ Email Address: _____

Postal Address: _____

_____ Postal Code: _____

B. Payment Instructions

Payments will only be made to the Policyholder's account.

No payments will be made to credit card accounts.

The company will not be liable for the loss of funds due to the provision of incorrect bank details by the Policyholder.

Account Name: _____ Account Number: _____

Bank: _____ Account Type: _____

Branch Code: _____ Account Holder Signature: _____

C. Patient Details

Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child Other: _____

Do not complete this section if the Patient is the Policyholder.

Title: _____ Full Name: _____

ID Number: _____

D. Event Details

If you are claiming for the Medical Scheme Contribution Waiver and Family Protector Benefits, please do not complete this section.

Where did the procedure take place: ☐ In-Hospital ☐ Doctors Rooms ☐ Casualty Ward

Reason for treatment: ☐ Accident ☐ Oncology ☐ Illness / Surgery

Hospital/Service Provider Name: _____

Reason for Hospitalisation/Treatment: _____

Admission/event date: D D M M Y Y Y Y Discharge date: D D M M Y Y Y Y

If this event was related to Oncology Treatment, please confirm the date you were first diagnosed: D D M M Y Y Y Y

E. Benefit Claimed | Medical Scheme Shortfalls and Co-Payments:

Service Date	Service Provider	Charged Amount	Medical Scheme Paid	Shortfall you are Claiming	Have you paid the Service Provider	
					Yes ☐	No ☐
					Yes ☐	No ☐
					Yes ☐	No ☐
					Yes ☐	No ☐
					Yes ☐	No ☐

F. Event Details | Medical Scheme Contribution Waiver and Family Protector:

Select the benefit you are claiming for: ☐ Medical Scheme Contribution ☐ Waiver Family Protector

Was the Death or Disability due to an accident? ☐ Yes ☐ No *Only accidents are covered*

Date of Death/Accident: D D M M Y Y Y Y *Please attach a copy of the Medical Scheme Membership Certificate*

Details leading to disability: _____

Medical Scheme Premium: _____ **(Amount in Rands)** *Please attach a copy of the Death Certificate and Police Report*

G. Event Details | Hospital Booster:

Admission Date	Discharge Date	Service Provider

H. Event Details | Family Booster:

Due Date	Birth Date

I. Event Details | Mediclinic Extender Cancer Lump Sum Benefit:

Diagnosis Date	Type of Cancer	Is this a first time diagnosis	
		Yes ☐	No ☐
		Yes ☐	No ☐

J. Declaration

I declare that the information, including all supporting documentation, provided to Kaelo in support of my claim is true and correct. I understand that any non-disclosure or false information my result in my claim not being paid or the cancellation of my cover. In order to ensure we are doing all we can to help you, we are able to source certain claims information through our SwitchAssist process in partnership with Med Claim Assist. By signing this declaration you are giving Kaelo permission to access any outstanding documentation or information relating to this claim via Med Claim Assist.

Kaelo Risk (Pty) Ltd reserves the right to negotiate a discounted rate with the relevant service providers on your behalf, if a discount is granted, payment will be made directly into the respective service provider's/Doctor's bank account thus rendering the Payment Instruction on the Claim Form null and void.

I consent to Centriq, and its operators, processing, and further processing, my personal information in accordance with the Protection of Personal Information Act, for the purposes of concluding, and performing in terms of, this insurance contract.

Full Name: Signature:

Date: D D M M Y Y Y Y

Please return the completed claim form to:

E-mail address: sanlamclaims@kaelo.co.za

T 0861 111 167
E **sanlamclaims@kaelo.co.za**