ambledown FINANCIAL SERVICES (PTY) LTD
Ambledown is an Authorised Financial Services Provider, No. 10287

Pick n Pay
Gap supreme

GUARDRISK TAILORED RISK SOLUTIONS
Guardrisk Insurance Company Limited,
a licensed non-life Insurer and an authorised financial services provider (No.75)

Gap Supreme Claim form

Underwritten by Guardrisk Insurance Company Limited (GICL), a licensed non-life Insurer, Reg. No. 1992/001639/06 , FSP No. 75.

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

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).

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

Ambledown Financial Services (Pty) Ltd
PO Box 1862, Cramerview, 2060
Tel: 086 126 2533
Fax: 011 463 1665
Email: claims@ambledown.co.za

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
E-mail:	

Family doctor (GP) details

Name:

Telephone number: Area code

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 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? D D M M Y Y Y Y

Details of hospital admissions

Was hospitalisation a result of an accident/ injury? Yes ☐ No ☐

Hospital Name	Practice number	Ward type	Date admitted	Date discharged
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			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
		D D M M Y Y Y Y	Area code
		D D M M Y Y Y Y	Area code
		D D M M Y Y Y Y	Area code
		D D M M Y Y Y Y	Area code

Payment instructions

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: ☐ Current ☐ Transmission ☐ Savings

Source of funds:

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

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 3rd 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.

SIGNATURE OF THE INSURED PERSON

SIGNATURE OF PATIENT *(if different from the principal insured)*

DATE D D M M Y Y Y Y

(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 your broker or alternatively: Ambledown Financial Services (Pty) Ltd, PO Box 1862, Cramerview, 2060

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