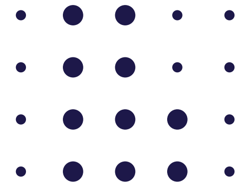
HEALTH / GAP COVER CLAIM FORM

(FSP no. 36571)



(FSP no.1596)

Telephone: 0861 000 509
Fax: 0861 000 508
Physical Address: 4 Osborne Lane, Bedforview, 2007
Postal Address: Private Bag X2, Gardenview, 2047

Policy Number:

A. DOCUMENTS REQUIRED

Turnberry must be notified of any claim within six (6) months calculated from the date of treatment and all documentation must be received within twelve (12) months. Please ensure that all documents requested below accompany your completed claim form to avoid unnecessary delays.

- Completed claim form
- Copy of your service provider's/doctor's account reflecting all transactions relating to the claim
- Copy of the hospital account
- Copy of your medical aid's statement reflecting all transactions relating to the claim/treatment. Unfortunately an "acknowledge of payment" issued by your medical aid does not provide the necessary information.

Please note, based on the information provided Turnberry may need to request additional information.

Please complete and return by fax to: 086 500 7532 or 086 673 4224 | Email to: claims@turnberry.co.za

B. DETAILS OF POLICYHOLDER

Title:

Gender: ◯ Male ◯ Female

ID Number:

Date of Birth:

Initials:

First Name:

Surname:

Residential or Physical Addresses:

Code:

Postal Addresses:

Code:

WorkTel No.

Cellular Tel No.

Fax No.

Home Tel No.

Email:

C. MEDICAL AID DETAILS

Company	Option	Medical Aid Number

D. DETAILS OF PATIENT

Surname: ______ Title: ______

First Names: ______

ID Number: ______ Date of Birth: ______

When was the patient hospitalised: ______

Referring doctor/GP details (name & contact number): ______

Reason for hospitalisation: ______

When did the patient first receive treatment, consult with a medical service provider and/or receive advice in relation to the condition ?

______

Has the patient received treatment, consulted with a medical service provider and/or received advice in relation to the condition in the last 12 months? If so, please provide the date(s) of the consultation(s).

______

______

______

Is the claim for a child dependant over the age of 21? YES ◯ NO ◯

If yes, please provide details of tertiary education and/or proof that he/she is fully dependent on the Policyholder.

E. BANK DETAILS

Accountholder's Name	
Name of Bank	
Branch Name and Town	
Branch Code	
Account Number	

Type of account: Cheque ◯ Savings ◯ Transmission ◯

I declare that the banking details provided are correct, failing which, Turnberry is not liable for any losses, charges and expenses. I accept that it is my responsibility to notify Turnberry timeously of any changes in my banking details.

Please note: In terms of legislation, Turnberry is not permitted to pay any third party provider and benefits must be paid to the policyholder.

Signature of Accountholder: ______ Date: ______

Signature of Principal Insured Person: ______ Date: ______
(if different from accountholder)

F. DECLARATION BY THE POLICYHOLDER

"I warrant that I am legally entitled to receive the benefits in terms of the said policy. Turnberry shall not be liable for payment if the cause of accident/illness is related to an exception detailed in the policy document and any endorsements thereto. In support of a claim in terms of the said policy, I declare that all statements and answers which may now or at any time be given in connection with this claim, whether in my handwriting or not, are true and complete. I understand that any misstatement or non-disclosure, which materially affects the assessment of this claim, will entitle Turnberry to declare this claim null and void. I hereby authorise the patient's medical aid, any hospital, medical service provider or any other person who has attended to or examined the patient, to furnish to Turnberry or Medwyze (Turnberry's 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.

Should any benefit be paid by Turnberry and subsequently settled, in whole or part, by the patient's medical aid or the medical service provider reduced the amount they have charged, the amount of the overpayment will be refunded to Turnberry."

Signature: ______ Date: ______