



Ambledown is an Authorised Financial Services Provider, No. 10287



# Absa Gap Cover Series

## Dread Disease / Severe Illness Claim Form

Underwritten by Absa Insurance Company Limited (AIC) FSP No: 8030; Registration number: 1992/001373/06

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 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 and provide supporting documentation as soon as possible). The claim will be assessed and a decision made within ten (10) working days from receipt of all the correct documents. If there are any unforeseen delays, these will be communicated and an indication given of the expected date of a final decision.

BEFORE ANY CLAIM CAN BE SETTLED, COPIES OF THE FOLLOWING DOCUMENTATION RELATING TO THIS PARTICULAR CLAIM/S ARE REQUIRED:

1. Histology report
2. Oncology Treatment Plan

Ambledown Financial Services (Pty) Ltd, PO Box 1862, Cramerview, 2060

**Tel:** 086 126 2533  
**Fax:** 011 463 1665  
**Email:** claims@ambledown.co.za

*(Failure to provide all applicable documentation to this claim form will cause undue delay in the processing thereof)*

### Principal insured member details

#### Applicant

Title:	Surname:	First names:
ID / passport number:		
Date of birth (DD/MM/YYYY):		
Policy / Member number:		

### Contact details

Postal address	Physical address (if different to postal)
Postal code:	Postal code:
Home number:	Employer:
Cell number:	Employer contact number:
Email:	

### Family doctor (GP) details

Name:
Telephone number:

### Patient details

First names:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Surname:	Relationship to principal member:	
ID / Passport number:	Self <input type="checkbox"/>	Spouse <input type="checkbox"/>
Date of birth (DD/MM/YYYY):	Child <input type="checkbox"/>	Other <input type="checkbox"/>
Medical scheme option:	Medical scheme name:	Scheme number:
Is the claim in respect of a dependent child over 21 years of age?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Reason for hospitalisation:		
When did the patient first receive treatment and/or advice in the above regard? (DD/MM/YYYY)		

NOTE: ONLY APPLICABLE TO POLICIES WITH THE DREAD DISEASE / SEVERE ILLNESS BENEFIT



## Providers / Doctors details

Name	Practice number	Date of service (DD/MM/YYYY)	Telephone number



## Payment instructions

Should benefits be paid into the bank account from which your policy premiums are collected? Yes  No

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
Are the benefits being paid into the bank account of a person/ entity that is not an insured person on the policy?			Transmission
Yes	<input type="checkbox"/>	Savings	
No	<input type="checkbox"/>	If yes, state the relationship:	

SIGNATURE OF ACCOUNT HOLDER	SIGNATURE OF PRINCIPAL INSURED MEMBER <i>(if different from account holder)</i>	DATE (DD/MM/YYYY)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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The company will not be liable for the loss of funds due to the provision of incorrect bank details by the member.



## Declaration and mandate

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 dependents, 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 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.

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.nt.

SIGNATURE OF THE INSURED PERSON	SIGNATURE OF THE PATIENT <i>(if different from account holder)</i>	DATE (DD/MM/YYYY)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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*(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:



# Broker details

Name:

Telephone number:

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Email:

**Please return to your broker or alternatively:** Ambledown Financial Services (Pty) Ltd, PO Box 1862, Cramerview, 2060  
 Tel Number 0861 262533, Fax Number 011 463 1600, E-mail Address: admin@ambledown.co.za

