LIBERTY HEALTH

Claim Form 2020 - Gap Cover Policy

Return address and Zestlife contact details:

E-mail: info@zestlife.co.za or fax: 021 001 0248 or post to PostNet Suite #87, Private Bag X1005, Claremont, 7735
Claim enquiries and queries – Zestlife tel: 021 180 4220 / 0860 009 378

Let's work together to process your claim quickly. What we need from you is to please complete this form and attach all the documents needed (Claim Pack) in order to ensure that your claim is processed as fast as possible. Processing of your claim cannot start until we have this completed claim form and all the listed documents. Please only submit one Claim Pack per claim incident. You must notify us of a claim within six months of the claim incident date. Any other documents requested must be submitted within 12 months of the claim incident date.

1. Policyholder details

Full names	
Surname	
Date of birth	DD/MM/YYYY
ID number	
Policy number	
Address	
Postal code	
Telephone landline number	Cell number
E-mail address	
Medical aid name	
Medical aid plan type	Total number of people on your medical aid
Medical aid membership number	

Declaration by policyholder and permission to share information with a third party

I declare that the above information is true, that I have withheld no material information and that all relevant documentation is attached to this claim form.

I authorise my medical aid, any hospital, medical practitioner or other person who has attended to me or my dependants, or examined me or my dependants, to furnish to Zestlife, Guardrisk or their authorised representative any information with respect to any illness or injury, medical history consultation, prescriptions or treatment and copies of all hospital or medical records. Such information could relate to medical information (i.e. PMB details, chronic conditions, claims transaction history, hospital procedures, health records etc.) or benefit information (i.e. plan type, limits, waiting periods, co-payments, self-payment gap etc.).

I further authorise Zestlife, Guardrisk or their authorised representative to share any information obtained as referred to above with my appointed Gap Cover Financial Advisor.

Signature of policyholder or appointed executor if policyholder is deceased | Date DD/MM/YYYY

2. Policyholder bank account details

Please provide the bank details of the policyholder. The benefit cannot be paid into a business bank account or to third party. The claim proceeds may be paid directly to the relevant service provider at the discretion of Zestlife.

Name and surname of account holder			
Bank name			
Branch code		Account type	
Account number			

3. Patient details

Full names							
Surname							
Date of birth	DD/MM/YYYY						
ID number (compulsory for processing this claim)							
Relation to insured	Self		Spouse		Child		Adult dependant	
Reason for claim	Illness		Accident		Childbirth		
Was the procedure an elective procedure? **Please tick box**	Yes		No				
Was the procedure due to an illness or medical condition? **Please tick box**	Yes		No				
Date admitted to hospital	DD/MM/YYYY						
Date discharged from hospital	DD/MM/YYYY						
Name of hospital/day clinic							
Description of treatment received							

To be completed ONLY if you have held the policy for less than 12 months:

When did the medical condition leading to your claim first occur	DD/MM/YYYY	Date of first consultation with a doctor for this condition	DD/MM/YYYY

Name and contact details of doctors/specialists

	Name	Telephone number
General Practitioner/House Doctor		
Treating Doctor		
Doctor who made the diagnosis		

Details of any medical treatment or consultations received in the 12 months prior to the cover start date.	

To be completed ONLY if the procedure was due to an accident as indicated above:

Date of accident	DD/MM/YYYY
Details of accident	

4. Type of Gap claim - Please tick the boxes which correspond with what you are claiming for. You only need to complete the sections that are relevant to your claim.

Medical practitioner cost shortfalls	☐	*Complete section A*	Co-payment/deductible	☐	*Complete section A*
Internal prosthesis shortfall	☐	*Complete section A*	Casualty ward shortfalls	☐	*Complete section A*
Accident tooth fracture benefit	☐	*Complete section B*	Extended Dentistry benefit	☐	*Complete section C*
Lump sum benefit for first time cancer	☐	*Complete section D*	Extended Cancer benefit	☐	*Complete section D*
Oncology treatment 20%/25% co-payment	☐	*Complete section E*	Non-affected breast reconstruction benefit	☐	*Complete section F*

Please request a special claim form if you want to claim for:
- Accidental death or disability Medical Premium Waiver benefit.
- Accidental death or disability Lump sum benefit.
- Trauma counselling.

Section A - Medical practitioner cost shortfalls, co-payment or deductible, internal prosthesis shortfall or casualty ward claim

The procedure was | In-hospital ☐ | Out of hospital ☐ | Casualty ward ☐

Date of service	Service providers (ie name of hospital, specialist, anaesthetist, doctor etc)	Total charged	Paid by Medical scheme	Shortfall	Have you paid the DR or is the balance still due?
		R	R	R	
		R	R	R	
		R	R	R	
		R	R	R	

We can pay your claim faster if you fully complete the section above and provide all the listed documents below, at the outset when you submit this claim form. We can only start processing a claim once we have all the listed documents.

Documents to attach for a medical practitioner cost shortfalls, co-payment or deductible, internal prosthesis shortfall or casualty ward claim:

1. Detailed medical aid statements reflecting payment to all medical practitioners a shortfall is being claimed for and the co-payment or deductible. ☐
2. Medical aid pre-authorisation letter reflecting the co-payment or deductible. ☐
3. Medical practitioner accounts (ie doctor, specialists, anaesthetist, etc). ☐
4. Hospital account (first 4 pages and pages reflecting internal prosthesis costs). If a casualty ward claim, a copy of the casualty ward account. ☐
5. Proof that the co-payment or deductible was paid (receipt or credit card slip). ☐

Section B - Accidental tooth fracture benefit

Number of teeth damaged ☐

Date of accident DD/MM/YYYY

Details of accident

We can pay your claim faster if you fully complete the section above and provide all the listed documents below, at the outset when you submit this claim form. We can only start processing a claim once we have all the listed documents.

Documents to attach for an accidental tooth fracture benefit:

1. Dentist motivation of accidental injury and invoice reflecting damaged tooth number. ☐
2. If the patient is not the policyholder, a recent medical aid membership schedule reflecting that the patient is a dependant of the policyholder; or the detailed medical aid statement reflecting payment to the medical practitioner (dentist etc). ☐

Section C - Extended Dentistry benefit (Only available for policyholders who have this benefit)

Dentist name	
Dentist practice number	
Date of visit	DD/MM/YYYY

Diagnosis	Possible Treatment	Cover	Mark with X	Tooth numbers
Impacted wisdom tooth	Surgical tooth removal	R1 000 per tooth		
Periodontitis	Gum surgery	R1 750 per event		
Jaw fracture	Surgery	R16 500 per event		
Dental Emergency	Emergency Root Canal, temporary crown, temporary filling.	R1 250 per event		
Accidental tooth fracture	Crown, splinting, bridge	R4 500 per tooth		
Severely decayed or damaged tooth	Crown	R3 250 per tooth		
Impaired function due to loss of teeth	Removable denture	R5 500 per jaw		
Occlusal instability	Implant or bridge	R10 000 per tooth		

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Documents to attach for a Extended Dentistry benefit claim:

1. Dentist quote or invoice for the procedure.
2. Dentist X-ray for tooth.
3. If the patient is not the policyholder, a recent medical aid membership schedule reflecting that the patient is a dependant of the policyholder.
4. If a periodontitis claim then also a copy of the periodontitis treatment plan.

Section D - Lump sum benefit for first time stage 2 cancer diagnosis and Extended Cancer benefit

Give full details of type of cancer	
Name of doctor who made the diagnosis	
Telephone number	
Date of diagnosis	DD/MM/YYYY
Is this a first time cancer diagnosis?	Yes ☐ No ☐

We can pay your claim faster if you fully complete the section above and provide all the listed documents below, at the outset when you submit this claim form. We can only start processing a claim once we have all the listed documents.

Documents to attach for a lump sum benefit for first time cancer diagnosis and Extended Cancer benefit claim:

1. Medical reports to be completed by medical practitioner (refer to the form on the last page of this document).
2. Histology reports and test results.
3. If the patient is not the policyholder, a recent medical aid membership schedule reflecting that the patient is a dependant of the policyholder.
4. Proof that the patient is registered on the medical scheme's oncology programme.

Section E - Oncology treatment programme co-payment

Give full details of type of cancer	
Treating doctor	
Telephone number	
Date of diagnosis	DD/MM/YYYY

Date of service	Service provider (ie name of hospital, specialist, anaesthetist, doctor etc)	Total charged	Paid by Medical scheme	Co-payment
		R	R	R
		R	R	R
		R	R	R

We can pay your claim faster if you fully complete the section above and provide all the listed documents below, at the outset when you submit this claim form. We can only start processing a claim once we have all the listed documents.

Documents to attach for an oncology treatment programme co-payment:

1. Treatment plan. ✔
2. Detailed medical aid statements reflecting payment to all medical practitioners a shortfall is being claimed for. ✔
3. Medical practitioner accounts (ie doctor, specialists, anaesthetist, etc). ✔

Section F - Non-affected breast reconstruction benefit

Date of mastectomy procedure: DD/MM/YYYY

Date of service	Service provider (ie name of hospital, specialist, anaesthetist, doctor etc)	Total charged	Paid by Medical scheme	Shortfall
		R	R	R
		R	R	R
		R	R	R

We can pay your claim faster if you fully complete the section above and provide all the listed documents below, at the outset when you submit this claim form. We can only start processing a claim once we have all the listed documents.

Documents to attach for a Non-affected breast reconstruction benefit:

1. Medical reports supporting the illness as well as copies of any relevant test results. ☐
2. Proof of the single mastectomy of the affected breast due to cancer – a copy of the histopathology report. ☐
3. Medical aid pre-authorisation letter. ☐
4. Detailed medical aid statement reflecting payment to all medical practitioners a shortfall is being claimed for and the co-payment or deductible. ☐
5. Medical practitioner accounts (ie doctor, specialists, anaesthetist, etc). ☐
6. Hospital account (full account). ☐

MEDICAL REPORT FOR CANCER LUMP SUM BENEFIT

THE BELOW FORM IS ONLY NEEDED IF YOU ARE CLAIMING FOR THE CANCER LUMP SUM BENEFIT

To be completed by the patient's attending Medical Practitioner only

Full names of patient				
When were you first consulted by the patient in connection with his/her condition?			On what date was the patient diagnosed with cancer?	
Is this the patient's first diagnosis of any type of cancer ?	Yes	No	If no, when was the patient first diagnosed with cancer?	
Please provide details of any previous diagnosis of cancer				
Please provide full details of current diagnosis of cancer and ICD 10 code				

If the cancer staging has progressed since the initial diagnosis, please provide the date the progression was confirmed.	DD/MM/YYYY

Please clarify the severity of the current diagnosis	**Stage**				Local	Regional	Benign	Malignant
	1	2	3	4				
Please provide full details of oncology treatment plan								

Medical Practitioner Declaration

I hereby certify that the above statements are true in every respect.	
Name	
Qualifications	
Physical Address:	
Telephone No:	
Practice No.	

Medical Practitioner Signature

Date