GapCover®

Claim Form

GapCover® medical shortfall solutions

western Rethink Insurance

A Policy Holder Details

Title: | Initials: | Surname:

ID/Passport No: | Policy No:

Medical Scheme: | Option:

Membership No:

B Claim Details

Practice Name	Practice No	Service Date	Patient Name	Unpaid Amount

All GapCover® and/or CoPay claims must be accompanied by the following documents:

1. Copy of the hospital account. (Please contact the hospital for a copy.)
2. Copy of the doctor/s account(s). (Please contact the doctor/s for a copy.)
3. Copy of the medical scheme claim statement, reflecting processing and payment of the applicable account/s.
4. Authorisation confirmation from your medical scheme.
5. Copy of the latest (not older than 3 months) medical scheme membership certificate.
6. Should the bank details for payment of claims differ from the debit order bank details, proof of bank details must be provided in the form of a bank statement.

NB: Claims must be submitted to GapCover® within 4 months after the scheme payment date.
NB: Claims cannot be processed until all the required documents have been received.

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.

C Banking Details (Claim Refunds)

Account Holder:

Name of Bank: Branch Code:

Account No.: Account Type: Cheque ☐ Transmission ☐ Savings ☐

Contact No/s: H W C

The administrator does not accept responsibility for payments made to incorrect bank details provided above.

Date: D D - M M - Y Y Y Y Signature of Account Holder:

D Protection of Personal Information Act (POPIA) Notice

1. Collection of your Personal Information

We collect and process your personal information mainly to provide you with access to our services and products, to help us improve our offerings to you and for certain other purposes explained below.

The type of information we collect will depend on the purpose for which it is collected and used. We will only collect information that we need for that purpose.

We collect information directly from you where you provide us with your personal details, for example when you purchase a product or services from us or when you submit enquiries to us or contact us. Where possible, we will inform you what information you are required to provide to us and what information is optional.

2. Use of your Personal Information

GapRisk collects and uses your personal information to deliver the services you have requested. GapRisk may also contact you from time to time via surveys to conduct research about your opinion of current services or of potential new services that may be offered when necessary. GapRisk does not sell, rent or lease its customer lists to third parties.

3. Protection of your Personal Information

GapRisk values the information that you choose to provide and will take appropriate, reasonable technical and organisational steps to protect your personal information from loss, misuse or unauthorised alteration. The information GapRisk has concerning GapRisk clients is stored in databases that have built-in safeguards to ensure the privacy and confidentiality of that information.

4. Correction of Personal Information

You have an obligation to notify us if any of your personal information held by GapRisk changed or is no longer valid. To ensure our records are up to date, you can e-mail us or you can phone our contact centre as supplied on our website, under “contact us”.

Additional detail regarding the use of personal information is set out in our Privacy Policy that can be viewed on our website www.gaprisk.co.za/privacy-policy/ or www.gapcover.co.za/privacy-policy/.

E Consent

I specifically consent to GapRisk Administrators contacting my current Medical Scheme and/or medical practitioner to verify any medical details as provided in my claim form. I further consent to such information being disclosed to GapRisk Administrators for purpose of verifying the disclosed information as provided on my application form.

I authorise GapRisk Administrators to negotiate with service providers on my behalf for my medical claims and/or bill and pay the provider direct.

Date: D D - M M - Y Y Y Y Signature of Policy Holder:

Information Consent Form

GapRisk constantly strives to maximise the benefit you, our valued customer, get from your gap cover policy. We have therefore procured the services of a specialist third party claims assessor, **MedClaim Assist (MCA)**, to determine if claims have been incorrectly short paid by your medical scheme, or if your medical provider has made errors on their invoice resulting in incorrect payment by your medical scheme. In this way, we ensure that your gap cover benefits are not misused which could result in benefits running out prematurely and/or excessive premium increases in future years.

By completing and signing this form, you give consent to **GapRisk**, to share your policy and claims information with **MCA**. This form gives GapRisk permission to make information available to MCA outlined below and you reserve the right to revoke this consent if there is a breach of any terms and conditions of this agreement or any rules by either of the parties.

Consent;
I the principal member, hereby give permission and declare that the permission of all my dependants was obtained, for MCA to access my and/or my registered dependants personal and medical information and to make enquiries in this regard from the date indicated below and furthermore also request documents in respect of my and/or my registered dependants, personal and medical information.

Neither GapRisk Administrators nor its affiliates, consultants or employees will be liable for any damages whatsoever, including without restrictions, any direct, indirect, special, incidental, consequential or exemplary damages whether arising from a contract, act, delict or otherwise, related to the provision of any information to MCA or any changes made by this third part as a result of this instruction given by me to my medical scheme.

By consenting, I agree to
1. My information being made available to MCA through GapRisk for the purposes outlined here.
2. I give consent to GapRisk and MCA that they may make contact with me and/or my dependants medical practitioners, should any clinical information of me or my dependants need to be discussed or further intervention required pertaining to my claim.
3. MCA is contracted with medical practitioners and pay the claims directly, I therefore consent that MCA may proceed with the payments of the claims directly to the practitioner.
4. I give consent to GapRisk and MCA to contact me or my dependants in the event that they require further information from my medical aid. I'm aware that MCA will make contact with my medical aid in the event that they require further information and therefore will expect additional consent from MCA directly.

Agreement;

I indicate my full understanding and agreement to consent to use MedClaim Assist.

My signature below indicates my understanding of an agreement to comply with the terms of this consent form.

Name: | Surname:

ID number:

Signed at (town or city): | On: D D - M M - Y Y Y Y

Please print name

Signature of person giving permission
Please only sign if information is true, complete and correct