Total Risk Administrators

GAP COVER CLAIM FORM

TOTALRISKADMINISTRATORS
An authorised financial services provider (FSP no. 40815)
T: (011) 372 1540 | **F:** (011) 372 1579
www.totalrisksa.co.za

IMPORTANT INFORMATION!

Please complete the following form and return it to Total Risk Administrators for attention GAP CLAIMS DEPT. as follows: Via e-mail to claims@totalrisksa.co.za OR by fax to (011) 372 1579 OR by post to P.O. Box 1181, Parklands, 2121

FOR OFFICE USE ONLY

Date received Y Y M M D D | Policy Number

Date captured Y Y M M D D | Captured by

Documents needed: ☐ Hospital Account ☐ Medical Aid Statement ☐ Service Provider Statement

SECTION 1: PERSONAL DETAILS

Medical Scheme | Med Aid No

Option | Gap Policy No

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Other | Initials

First Names **(in full)**

Surname

Date of Birth Y Y M M D D | ID Number

Contact Numbers

Email Address

POSTAL ADDRESS	COMMENTS
Code	

SECTION 2: CLAIM DETAILS

Beneficiary Name	Treatment Date	Provider Name	Practice Number	Amount Charged
	Y Y M M D D			
	Y Y M M D D			
	Y Y M M D D			
	Y Y M M D D			

It is very important that the medical aid statement reflecting the claims submitted, the hospital account and the doctors statements are provided with this claim! If these documents are not attached it will be considered an invalid claim.

SECTION 3: BANKING DETAILS

Bank | Branch

Account Number | Branch Code

Account Holder Cheque ☐ Savings ☐ Transmission ☐ Other

I, _____

the undersigned, declare that the aforegoing details are, to the best of my knowledge true, correct and complete.

MEMBER SIGNATURE

Date Y Y M M D D

As per the terms and conditions of this policy all the required information must be submitted to TRA within 3 months of the date of medical aid processing the claim after which the claim will be considered "stale". Refunds are made directly into the member's bank account.