Total Risk Administrators

GAP COVER CLAIM FORM

TOTALRISKADMINISTRATORS

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

Underwritten by: auto & general

Auto & General Insurance Company Limited,
an Authorised Insurer & Financial Services Provider
Reg No 1973/016880/06

IMPORTANT INFORMATION!

Please complete the form and return to Total Risk Administrators for attention TRA Claims Department via email to claims@totalrisksa.co.za OR by fax to 011 372 1579 OR by post to P.O. Box 8012, Greenstone, 1616

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 Claimed
	Y Y M M D D			
	Y Y M M D D			
	Y Y M M D D			
	Y Y M M D D			
			TOTAL	

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

SECTION 3: REQUIRED DOCUMENTATION

The following documentation is required BEFORE a claim can be processed:

☐ First 2 pages of Hospital Account ☐ Medical Aid Statement ☐ Doctor / Service Provider Statement

Please use the tick boxes above to ensure you have included the required documentation.

Please include the following documentation in the case of a CO-PAYMENT claim:

☐ Medical Aid Pre-authorisation letter showing requirement of co-payment

☐ Proof of payment of co-payment to provider

SECTION 4: POLICYHOLDER'S BANKING DETAILS - FOR CLAIMS REFUND PURPOSES

Bank		Branch	
Account Number		Branch Code	

Account Holder Cheque ☐ Savings ☐ Transmission ☐ Other

I, _____

the undersigned, declare that the afore-going 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 6 months from date of treatment after which the claim will be considered "stale".
Refunds are generally made directly into the policyholder's bank account.