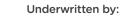


**TOTALRISKADMINISTRATORS** 

## Total Risk Administrators



GAP COVER CLAIM FORM

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

auto 📢 general

An authorised financial services provider   FSP no. 4081
--

T: 011 372 1540 | F: 011 372 1579 | www.totalrisksa.co.za

			IMPO	RTANT I	NFORM	ATION!										
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 M M D D															
Date captured	Y M M D D															
Documents needed:	Hospital Account		Med	dical Aic	l Staten	nent	[		Serv	ice Prc	ovide	r State	emen	t		
	SECTION 1: PERSONAL DETAILS															
Medical Scheme					Med Ai	d No										
Option		Gap Po	licy No													
Title	Mr	Other Initials														
First Names (in full)																
Surname																
Date of Birth	Y Y M M D E				ID Num	nber										
Contact Numbers																
Email Address																
POSTAL ADDRESS COMMENTS																
		Code														
SECTION 2: CLAIM DETAILS  Treatment Practice Amount																
Benefi		ate		Provider Name						Number Clain						
		Y Y M		D						_			_			
		Y Y M		D D									_			
				D									_			
							тот	AL								
It is very impor	tant that the medica	al aid state	ement r	eflectin	g the cl	aims suk	omit	ted, 1	the h	nospita	al aco	count	and t	he do	octor	's
statements a	are provided with th								vill b	e cons	sider	ed an	inval	id cla	im.	
The fellowing states				REQUIR												
	umentation is required	Г								octor /		vice Du	rouid.		+	+
	s of Hospital Accour boxes above to ensu	L		edical Ai ed the re			tatic	n Dn		JCLOF /	Ser	vice Pi	OVIGE	er Sta	terne	3111
	following documenta															
Medical Aid F	Pre-authorisation lette	er showing	requirer	ment of (	co-paym	ent										
Proof of payr	ment of co-payment	to provider														
	SECTION 4: POLIC	CYHOLDEI	R'S BAI		DETAILS	5 - FOR	CLA	IMS	REF		PURF	OSES	;			
Bank					Brancl	ſ										
Account Number					Brancl	n Code										
Account Holder	Cheque S	avings		Transmi	ssion	Ot	ther									
l,																
the undersigned, de	eclare that the afore-g	oing detail	s are, to	the bes	t of my l	knowledg	ge tr	ue, co	orrec	t and c	comp	lete.				
	MEMBER SIGNATU	IRE									D	ate 🗌	Y Y	M	M D	D
As pe	r the terms and cond	itions of th	is polic	y all the	required	linforma	ation	n mus	t be	submit	ted t	o TRA	with	in		