





**PART 1 – SHORTFALL IN MEDICAL PRACTITIONER COSTS**

**This benefit pays up to 3 times the amount paid by your medical aid for each service undertaken by the practitioner.**

**We process your claim on a line-by-line level according to your medical practitioner's account and some of these charges may not be covered. This means that we may not pay your claimed shortfall in full.**

*Exclusions to this benefit include (but are not limited to) hospital and day clinic fees and ward/theatre charges, medication and materials, appliances and fees related to BMI, obesity or body weight.*

This procedure was: In hospital  Out of hospital  As a result of an accident: Yes  No

Date admitted: 

d	d	m	m	y	y	y	y
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 Date discharged: 

d	d	m	m	y	y	y	y
---	---	---	---	---	---	---	---

Name of hospital / day clinic:

Procedure undertaken:

Date of service	Medical service provider	Total charged	Medical aid paid	Shortfall								
<table border="1" style="display: inline-table;"><tr><td>d</td><td>d</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td></tr></table>	d	d	m	m	y	y	y	y		R	R	R
d	d	m	m	y	y	y	y					
<table border="1" style="display: inline-table;"><tr><td>d</td><td>d</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td></tr></table>	d	d	m	m	y	y	y	y		R	R	R
d	d	m	m	y	y	y	y					
<table border="1" style="display: inline-table;"><tr><td>d</td><td>d</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td></tr></table>	d	d	m	m	y	y	y	y		R	R	R
d	d	m	m	y	y	y	y					
<table border="1" style="display: inline-table;"><tr><td>d</td><td>d</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td></tr></table>	d	d	m	m	y	y	y	y		R	R	R
d	d	m	m	y	y	y	y					
Total shortfall being claimed				R								

**Supporting documents to be submitted** (please tick that you have attached each of the below documents):

Hospital/day-clinic account (showing date of admission & discharge, patient details, diagnosis code and each service)  Doctor account (for each doctor being claimed)  Medical aid statement (showing each service for each doctor being claimed)

**Please note that an online claims history or summary does not provide sufficient information – we need the complete PDF claim statement from your medical aid.**

**PART 2 – CO-PAYMENT**

**This benefit pays for certain co-payments that have been applied by your medical aid.**

*Exclusions to this benefit include (but are not limited to) co-payments that are for using a non-designated service provider, that relate to the use of a private ward and that apply to any procedure or condition in a waiting period.*

Co-payment was applied to: In-network hospital  Out-of-network hospital  As a result of an accident: Yes  No

Name of hospital / day clinic:

Date admitted: 

d	d	m	m	y	y	y	y
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 Date discharged: 

d	d	m	m	y	y	y	y
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Date of service	Medical service provider	Co-payment								
<table border="1" style="display: inline-table;"><tr><td>d</td><td>d</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td></tr></table>	d	d	m	m	y	y	y	y		R
d	d	m	m	y	y	y	y			
<table border="1" style="display: inline-table;"><tr><td>d</td><td>d</td><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td></tr></table>	d	d	m	m	y	y	y	y		R
d	d	m	m	y	y	y	y			
Total		R								

**Supporting documents to be submitted** (please tick that you have attached each of the below documents):

Pre-authorisation letter (reflecting co-payment applied) or detailed medical aid statement (reflecting co-payment applied)  Proof of payment  Hospital account (showing co-pay charged, date of admission & discharge, patient details, diagnosis code & services)

## PART 3 – ONCOLOGY CO-PAYMENT

This benefit pays out up to 20% of co-payments applied by your medical aid once the annual oncology treatment limit has been reached.

Exclusions to this benefit include (but are not limited to) treatment undertaken by a non-designated service provider.

This is the 1st  2nd  3rd  4th  5th  oncology co-payment claimed this year

Date of treatment								Medical service provider	Total charged	Medical aid paid	Shortfall
d	d	m	m	y	y	y	y		R	R	R
d	d	m	m	y	y	y	y		R	R	R
d	d	m	m	y	y	y	y		R	R	R
Total co-payments										R	

Supporting documents to be submitted (please tick that you have attached each of the below documents):

Test results (1<sup>st</sup> claim only)     Histology report (1<sup>st</sup> claim only)     Oncology treatment plan (1<sup>st</sup> claim only)     Annexure B (1<sup>st</sup> claim only)     Med. aid statement (each claim)     Service provider acc. (each claim)

## PART 4 – ONCOLOGY EXTENDER

This benefit pays out up to 20% of oncology treatment costs incurred once the annual oncology treatment limit on your medical aid has been reached.

Exclusions to this benefit include (but are not limited to) treatment undertaken by a non-designated service provider.

This is the 1st  2nd  3rd  4th  5th  oncology extender benefit claimed this year

Date of treatment								Medical service provider	Total charged
d	d	m	m	y	y	y	y		R
d	d	m	m	y	y	y	y		R
d	d	m	m	y	y	y	y		R
Total treatment costs								R	

Supporting documents to be submitted (please tick that you have attached each of the below documents):

Test results (1<sup>st</sup> claim only)     Histology report (1<sup>st</sup> claim only)     Oncology treatment plan (1<sup>st</sup> claim only)     Annexure B (1<sup>st</sup> claim only)     Med. aid statement (each claim)     Service provider acc. (each claim)

## PART 5 – SHORTFALL IN INTERNAL PROSTHESIS COSTS

This benefit pays for shortfalls in the cost of an internal prosthesis which replaces a body part. The maximum benefit payable under this benefit is R30 000 per policy per year.

Exclusions to this benefit include (but are not limited to) devices that assist with the functioning of a body part (e.g. pacemaker, stent, etc.) and external prosthesis or dental implants.

Date admitted: 

d	d	m	m	y	y	y	y
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      Date discharged: 

d	d	m	m	y	y	y	y
---	---	---	---	---	---	---	---

Name of hospital / day clinic:

Date of service								Medical service provider	Total charged	Medical aid paid	Shortfall
d	d	m	m	y	y	y	y		R	R	R
d	d	m	m	y	y	y	y		R	R	R
Total shortfall being claimed										R	

Supporting documents to be submitted (please tick that you have attached each of the below documents):

Hospital account (showing date of admission & discharge, patient details, diagnosis code and each service)       Medical aid statement (reflecting the prosthesis shortfall)

**PART 6 – ACCIDENTAL EMERGENCY CASUALTY**

This benefit will pay up to R10 000 of casualty ward costs incurred. This benefit is limited to 3 casualty visits per family per year, as long as each visit is both an accident and an emergency.

1 of these casualty ward visits may be due to an Emergency only, for a dependant that is five (5) years old or less on the date of the claim event. The benefit for this claim will be limited to R2 000 and it will accumulate to your three (3) claim events and R10 000 benefit limit per year.

Exclusions to this benefit include (but are not limited to) elective procedures undertaken in casualty and casualty ward visits due to illness, except for 1 visit for a dependant 5 years and younger.

Date of casualty visit: 

d	d	m	m	y	y	y	y
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 Time of casualty visit 

h	h	:	m	m
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This is the 1st  2nd  3rd  casualty visit for this year or 1 visit for your dependant child under 5

Date of birth of child:: 

d	d	m	m	y	y	y	y
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 When claiming for an emergency visit for your dependent child under 5

Name of medical facility: 

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Give full details of circumstances leading to the claim event as well as details of the injury

Date of treatment								Medical service provider	Total charged	Medical aid paid	Shortfall
d	d	m	m	y	y	y	y		R	R	R
d	d	m	m	y	y	y	y		R	R	R
d	d	m	m	y	y	y	y		R	R	R
d	d	m	m	y	y	y	y		R	R	R
d	d	m	m	y	y	y	y		R	R	R
Total shortfall being claimed										R	

Supporting documents to be submitted (please tick that you have attached each of the below documents):

Casualty admission form  Casualty account  Medical aid statement (showing amounts paid by the medical aid)

**PART 7 – LUMP SUM CANCER**

If diagnosed with minimum stage II, local and malignant cancer for the first time, we will pay you a once-off lump sum benefit of R5 000. If however, you are diagnosed with minimum stage II, regional and malignant cancer for the first time, we will pay you a once-off lump sum benefit of R15 000.

In addition, if you are successful in claiming the R15 000 benefit and the extent of treatment that you need results in your medical scheme paying R200 000 or more for your oncology treatment within your first one-year treatment cycle, we will pay you a further R10 000.

Exclusions to this benefit include (but are not limited to) all skin cancers and all cancers diagnosed and treated by primary biopsy only, where it does not require further surgical, medical or radiotherapy.

Which benefit are you claiming? 1st lump sum of R15 000  2nd lump sum of R10 000

Date of diagnosis 

d	d	m	m	y	y	y	y
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 Is this the first diagnosis of cancer? Yes  No

Supporting documents to be submitted (please tick that you have attached each of the below documents):

Test results  Histology report  Oncology treatment plan  Annexure B  Medical aid statement

**PART8 – LUMP SUM FOR ACCIDENTAL DEATH / PERMANENT TOTAL DISABILITY / VIOLENT CRIME BENEFIT**

This benefit pays out a lump sum of R50 000 in the event of accidental death or permanent and total disablement of an insured life. The accidental death benefit is limited to R10 000 for minors between the age of 0 and 5 years, and R30 000 between the age of 6 and 13 years.

If death or permanent and total disability is the result of a violent crime we will double the benefit amount paid out. The maximum death benefit pay-out for children is capped by legislation.

*Exclusions to this benefit include (but are not limited to) claim events that are NOT due to an accident.*

Date of accident/incident	d	d	m	m	y	y	y	y	Was the death or permanent and total disability due to a violent crime:	Yes	No
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Benefit being claimed:                      Death                       Disability

Give details of circumstances leading to the claim event:


**Supporting documents to be submitted** (please tick that you have attached each of the below documents):

Death certificate (if death)     Accident report (if death or disability)     Annexure A (if disability)     Police report                       Case Number

**PART 10 – PREMIUM WAIVER BENEFIT**

If you or a dependant who pays the monthly premium due on this policy, dies or become Permanently and Totally Disabled as a result of an Accident while covered under this policy, we will assist your dependants in covering the cost of their monthly medical scheme contributions and gap cover premium by paying them the equivalent of R5 000 per month for 6 months.

The full amount of R30 000 however, will be paid when processing the claim, and not in instalments over the 6-month period.

*Exclusions to this benefit include (but are not limited to) Death or Disability that is not due to an Accident as defined in the policy*

Date of accident/incident

d	d	m	m	y	y	y	y
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Benefit is being claimed due to :                      Death                       Disability

Is the Insured the premium payer on this policy:	Yes	No
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Give details of circumstances leading to the claim event:


**Supporting documents to be submitted** (please tick that you have attached each of the below documents):

Death certificate (if death)     Accident report (if death or disability)     Annexure A (if disability)

**PART 9 – TRAUMA COUNSELLING**

**This benefit pays R750 per counselling session and up to R25 000 per year for trauma due to being a victim of, or a witness to, an act of violence or a traumatic accident.**

*Exclusions to this benefit include (but are not limited to) counselling that is not related to an act of violence or a traumatic accident.*

Date of claim event	d d m m y y y y	3 <sup>rd</sup> Counselling session	d d m m y y y y
1 <sup>st</sup> Counselling session	d d m m y y y y	4 <sup>th</sup> Counselling session	d d m m y y y y
2 <sup>nd</sup> Counselling session	d d m m y y y y	5 <sup>th</sup> Counselling session	d d m m y y y y

Give details of the claim event that lead to the counselling session/s


**Supporting documents to be submitted** (please tick that you have attached each of the below documents):

Counsellor account       Proof of payment       Accident report       Police report

**PART 10 – BABY BUMP BENEFIT**

**If you are diagnosed as pregnant by your Medical Practitioner while covered on the policy, we will pay you a fixed amount of R2 000 to assist you with unexpected pregnancy costs.**

*Exclusions to this benefit include (but are not limited to) any pregnancy diagnosis which occurs before your cover with us begins*

Date of pregnancy diagnosis

d	d	m	m	y	y	y	y
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**Supporting documents to be submitted** (please tick that you have attached each of the below documents):

Quantitative (beta hCG) Test results       or      Proof of registration on medical scheme's maternity programme

**BROKER DECLARATION AND CONSENT – only applicable when broker is completing claim form on behalf of claimant/patient**

**Please initial each of the following sentences below to confirm that you are in agreement with the statement:**

- The claimant/patient has authorised you to complete this claim form on their behalf and you confirm that the information provided is true and accurate as advised by your client.
- You can provide proof of your client's above mentioned authorisation timeously on request by Guardrisk.
- You declare that you have read the below Claimant / Patient declaration and that your client is aware of each declaration you are signing on their behalf.

Date signed: 

d	d	m	m	y	y	y	y
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Signature of Broker \_\_\_\_\_

**CLAIMANT / PATIENT DECLARATION**

Please initial each of the following sentences below to confirm that you are in agreement with the statement:

1. You declare that the above and attached information is true, that you have withheld no material information and that all relevant required documentation is attached to this claim form
2. You confirm your understanding that if this claim form is incomplete or you have not submitted all required supporting documentation, Guardrisk may not process your claim
3. You confirm your understanding that should any material information be withheld or incorrectly furnished during the claim process, Guardrisk may cancel your cover and premiums paid may be used to offset expenses incurred by Guardrisk
4. You authorise Guardrisk to make claim payments to the account nominated in this form
5. You undertake to inform Guardrisk of any change in your banking details and you authorise Guardrisk to verify such banking details with your bank
6. You confirm that Guardrisk shall not be held liable for incorrect claim payments made as a result of your failure to inform Guardrisk of any change in banking details
7. You accept and understand that you are limiting your right to privacy. You authorise Guardrisk to obtain from any person, other insurer, medical scheme, medical practitioner/institution, any information that Guardrisk to facilitate the processing of this claim. You authorise such person(s) to give the said information to Guardrisk, and to share with other insurers and medical schemes any information in this claim form, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Guardrisk or the operators of such database may decide from time to time
8. You authorise the disclosure of relevant medical information by your medical scheme to Guardrisk to assist in the processing of claims under this policy. This information could include your (or one of your dependants') diagnosis, treatment and medical history.
9. You further confirm that your dependants and/or beneficiaries have also provided the necessary authority for your medical scheme to disclose their relevant medical information to Guardrisk to assist in the processing of claims under this policy.
10. You authorise Guardrisk to negotiate on your behalf with your medical scheme in respect of shortfall claims that may have arisen from medical events which your medical aid is legally obliged to cover in full (Prescribed Minimum Benefits).
11. You authorise Guardrisk to negotiate discounts on your and your dependants' behalf with medical service providers in order to maintain a good risk profile for your cover. If successful, you acknowledge that payment will be made directly to the service provider's bank account and no further payment will be due to you.
12. I authorise Guardrisk to disclose all relevant information to the appointed broker on my policy to assist in the processing of this claim. This information could include my (or one of my dependants') medical diagnosis, treatment and history as well as personal information. I further confirm that my dependants and/or beneficiaries have also provided the necessary authority to disclose their relevant information to the appointed broker to assist in the processing of any claims processed by Guardrisk on this policy.

Signature \_\_\_\_\_

Date \_\_\_\_\_



**ANNEXURE A**  
**DISABILITY REPORT FOR ACCIDENTAL PERMANENT AND TOTAL DISABILITY**  
*(Required for lump sum permanent and total disability benefit claims)*

**To be completed by the claimant's attending Medical Practitioner only**

Full names of claimant					
When were you first consulted by the claimant in connection with his/her injuries?			Are you still in attendance?	Yes	No
In your opinion, was the disability due to an accident?	Yes	No	Is the claimant permanently and total disabled from attending to any portion of his/her usual business or occupation?	Yes	No
What was the cause of the accident?					
What injuries were sustained?					
Please state the exact cause and nature of the disability					
Does the present disability relate in any way to previous injuries or pre-existing conditions or illnesses?	Yes	No	If yes, please provide detail		
Is the claimant now or was he/she at the time of the accident subject to, or suffering from, any illness or disease irrespective of the accident for which the benefit is claimed?	Yes	No	If yes, state the nature and to what extent the recovery of the claimant may be effected thereby?		
Please state any information not already mentioned which is relevant to the assessment of any permanent disability arising from the accident					
Based on your assessment, do you think the claimant will recover fully or partially?	Yes	No	If yes, please provide reasons		

**Medical Practitioner Declaration**

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**ANNEXURE B  
ONCOLOGY MEDICAL REPORT**

(Required for lump sum cancer claims, 1<sup>st</sup> oncology co-payment and 1<sup>st</sup> time oncology extender claims)

**To be completed by the claimant's attending Medical Practitioner only**

Full names of claimant			
Is this the claimant's first diagnosis of any type of cancer?	Yes	No	If no, when was the claimant first diagnosed with cancer?
Please provide details of any previous diagnosis of cancer			
Please provide full details of current diagnosis of cancer			

Please clarify the severity of the current diagnosis by marking the relevant box

Stage			
1	2	3	4

Please clarify the severity of the current diagnosis by marking the relevant box

Local	or	Regional
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Please clarify the severity of the current diagnosis by marking the relevant box

Benign	or	Malignant
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**Medical Practitioner Declaration**

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

Signature \_\_\_\_\_

Date \_\_\_\_\_