westerngap

shortfall cover

Claim Form

For more information on the benefits or claim procedures please contact
Kaelo on **0860 100 296 / 086 100 8258**

Kaelo Risk (Pty) Ltd is an authorised financial services provider: FSP 36931 a member of the Kaelo Group.
Underwritten by Western National Insurance Company Limited an authorised financial services provider. FSP 9465

In order for a claim to be valid, there are certain basic criteria that have to be met. These include, but are not limited to:

- Your contributions being paid up;
- You being a member of a valid South African medical scheme;
- You having been hospitalised (certain procedures such as an Endoscopic procedure, CT Scan and Chemotherapy does not require hospitalisation - Please refer to your policy document for the listed outpatient procedures that are covered);
- Your procedure not involving drug/alcohol rehabilitation or admission for depression or dental implants (please refer to the policy document for a full list of exclusions);
- Having obtained an authorisation number for the procedure from your medical scheme;
- Your specialist, ie your surgeon or your anaesthetist, having charged a higher rate than your medical scheme reimbursement rate, ie you having a shortfall;
- Your medical scheme option requiring you to pay a co-payment or upfront deductible (If a benefit is provided), not related to the use of network providers or authorisation/referral processes (unless a benefit is provided);
- You receiving accidental emergency treatment (as defined in the master policy) in a hospital casualty ward, and your medical scheme not covering this from the in-hospital risk portion of your medical scheme;
- You having exceeded your limit for oncology treatment;
- Your medical scheme option requiring you to pay a co-payment for oncology treatment;
- You spend 10 days or more in a stepdown or recovery facility following a severe hospitalisation event;
- The main member suffered an death, accidental death or total and permanent disability.

Once you have established that you have a valid claim, you will be required to complete a claim form, which you can obtain from your advisor/broker or alternatively from the Kaelo Customer Care Centre **(0860 100 296 / 086 100 8258).** Please note that this is not an automatic process, and you will be required to submit a separate claim form to the claim that has been submitted to your medical scheme. When submitting the claim form, you will also need to provide a copy of the relevant specialists' accounts, hospital accounts and medical aid statement showing the processing of the accounts and the shortfall. Please note that the claim will not be processed until all documents have been received. You have 6 months from the first day that you were hospitalised to submit your claim and relevant documentation. Any claim received for the first time after the 6 month period has expired, will not be honoured. Should a portion of the documentation be received within the 6 month period, the claim will be held pending for a further six month period, after which it will go stale and will not be honoured.

Claims can be faxed to **(086 609 2061)** or e-mailed to **western@kaelo.co.za** or be posted to:

Kaelo Claims
Claims Department
1st Floor, Kent House
1 Neptune road
Westville,3630

Once received, your claim will be processed and if all requirements have been met, the benefit amount will be paid within **7 to 14 working days.**

Please also remember that this policy does not form part of your medical scheme and your medical scheme call centre will thus not be able to assist you with any questions in this regard.

Please direct all queries to the **Kaelo Customer Care Centre on 0860 100 296 / 086 100 8258.**

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A Principal Member Details:

Surname:

Name:

ID Number:

Telephone:

Cellphone:

E-mail:

Employer Name:

Branch Name:

Date of Employment:

Medical Scheme:

Medical Aid No:

Benefit Option:

Postal Address:

Gap Policy No :

Code:

B Payment Instructions:

Account Holder Name:

Bank Name:

Account Number:

Account Type: ◯ Cheque ◯ Transmission ◯ Savings

Branch Name:

Branch Code:

Payments will only be made to the Principal Member's Account.
The company will not be liable for the loss of funds due to provision of incorrect bank details by the member

C Patient Details:

Title:

Initials:

Surname:

Name:

ID Number

Relationship to Main Member: ◯ Self ◯ Spouse ◯ Child Other:

D Where did the Incident Occur (Treatment Details):

Did the procedure take place: ◯ In-Hospital ◯ Doctors Rooms ◯ Casualty Ward

Was the Hospitalisation a result of an accident: ◯ Yes ◯ No

Hospital / Service Provider Name:

Procedure Details / Reason for hospitalisation:

Admission / Event Date:

Discharge Date:

Member Initials:

E Benefit Claimed: GAP / Oncology / Accidental Emergency

Date of service	Service Provider	Doctor Charged	Scheme Paid	Shortfall amount

F Benefit Claimed: Co-Payment / Maternity Booster / Step Down

Date	Service Provider	Amount	Benefit type (please tick)					
			Co-Payment		Step Down Facility		Maternity Booster	
			Co-Payment		Step Down Facility		Maternity Booster	
			Co-Payment		Step Down Facility		Maternity Booster	
			Co-Payment		Step Down Facility		Maternity Booster	

G Benefit Claimed: Premium Waiver / Lump sum Benefits

Did the procedure take place:

- ◯ Medical Scheme Premium Waiver
- ◯ Gap Cover Premium Waiver
- ◯ Accidental Cover
- ◯ Total Disability
- ◯ Death (Accidental)
- ◯ Permanent / Total Disability

Date of Death / Accident: ☐☐☐☐☐☐☐☐ *Please attach a copy of the Death Certificate and Police Report (if accident)*

Details leading to disability: ____________________

Medical Scheme Premium: ____________ *(Amount in Rands)* *Please attach a copy of the Medical Scheme Membership Certificate*

H Benefit Claimed: Oncology Lump sum Benefit

Type of Cancer: ____________________

Diagnosis date: ☐☐☐☐☐☐☐☐

Is this s a first time cancer diagnosis: ◯ Yes ◯ No

Member Initials: ☐

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I Declaration by Member:

I hereby declare that the person mentioned under claimant details is nominated under the abovementioned policy, that all the particulars given are true and complete, and that the hospitalisation was not wholly or partly, directly or indirectly, caused by the contingencies mentioned in both the General and Specific exceptions attached to the policy in question. I further declare that the above statements are true and that I have withheld no material information and that I undertake to furnish any documentation which may be required by the Insurance Company or its representatives. I expressly waive all provisions of law, custom or professional etiquette forbidding any physician or other person who attended or examined the claimant, or any institution in which the claimant received treatment, to disclose any knowledge or information which was thereby acquired and agree that this authority shall remain in force until cancelled in writing. I authorise all such persons or agencies to furnish any information in their possession to Kaelo or its representatives.

Kaelo (Pty) Ltd reserves the right to negotiate a discounted rate with the relevant service providers on your behalf, if a discount is granted, payment will be made directly into the respective service provider's bank account thus rendering the Payment Instruction on the Claim Form null and void.

Signature of Applicant: ______________________ Date: | | | | | | | | |

J Claims Checklist:

In order for us to assess your claim without any delays, please ensure you have attached the following documents:

GAP / ACCIDENTAL EMERGENCY / CO-PAYMENT / ONCOLOGY / STEP DOWN FACILITY	
CLAIM FORM	
RELEVANT DOCTORS ACCOUNTS	
MEDICAL CLAIMS STATEMENTS	
HOSPITAL (if hospitalised) / STEP DOWN ACCOUNT	
ONCOLOGY TREATMENT PLAN (Oncology claims)	

ACCIDENTAL / TRAUMA RELATED DENTAL IMPLANTS	
CLAIM FORM	
RELEVANT DOCTORS ACCOUNTS	
MEDICAL CLAIMS STATEMENTS	
HOSPITAL ACCOUNT	
DENTIST/SURGEON MOTIVATION (accident & oncology)	

MEDICAL SCHEME PREMIUM WAIVER / ACCIDENTAL DEATH & DISABILITY	
CLAIM FORM	
COPY OF DEATH CERTIFICATE	
POLICE REPORT (in case of accidental death)	
DISABILITY REPORT (attending doctor to complete)	
MEDICAL SCHEME MEMBERSHIP CERTIFICATE	

ONCOLOGY LUMP SUM BENEFIT (ONCOLOGY SUPPLEMENTARY BENEFIT ONLY)	
CLAIM FORM	
MEDICAL REPORTS	
HISTOLOGY REPORTS	
TEST RESULTS	
SCHEME ONCOLOGY TREATMENT PLAN	

K Please Return to:

Post: **Kaelo - 1st Floor, Kent House, 1 Neptune Road, Westville, 3630**

Fax: **086 609 2061**

Email: **western@kaelo.co.za**

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