zestlife
Cover you can trust.
People you can depend on.

RETURN ADDRESS AND ZESTLIFE CONTACT DETAILS:
E-mail: info@zestlife.co.za
Fax: 021 180 4375
Post: PostNet Suite #87, Private Bag X1005, Claremont, 7735
Tel: 021 180 4220 / 0860 009 378
Web: www.zestlife.co.za

Claim Form

Gap Cover Policy

Lets work together to process your claim quickly. What we need from you is to please complete this form and attach all the documents needed (Claim Pack) in order to ensure that your claim is processed as fast as possible. Processing of your claim cannot start until we have this completed claim form and all the listed documents. Please only submit one Claim Pack per claim incident. You must notify us of a claim within six months of the claim incident date. Any other documents requested must be submitted within 12 months of the claim incident date.

1. POLICYHOLDER DETAILS

Title | Full names

Surname

Date of birth (DD/MM/YYYY) | Identity number

Policy number

Address | Postal code

Cell phone number | E-mail address

Telephone landline number | Medical aid name

Medical aid plan type | Total number of people on your medical aid

Medical aid membership number

DECLARATION BY POLICYHOLDER AND PERMISSION TO SHARE INFORMATION WITH A THIRD PARTY

I declare that the above information is true, that I have withheld no material information and that all relevant documentation is attached to this claim form.

I authorise my medical aid, any hospital, medical practitioner or other person who has attended to me or my dependants, or examined me or my dependants, to furnish to Zestlife, Guardrisk or their authorised representative any information with respect to any illness or injury, medical history consultation, prescriptions or treatment and copies of all hospital or medical records. Such information could relate to medical information (i.e. PMB details, chronic conditions, claims transaction history, hospital procedures, health records etc.) or benefit information (i.e. plan type, limits, waiting periods, co-payments, self-payment gap etc.).

I further authorise Zestlife, Guardrisk or their authorised representative to share any information obtained as referred to above with my appointed Gap Cover Financial Advisor.

Signature of policyholder or appointed executor if policyholder is deceased_____ DD/MM/YYYY

2. POLICYHOLDER BANK ACCOUNT DETAILS

Please provide the bank details of the **policyholder**. The benefit cannot be paid into a business bank account or to a third party. The claim proceeds may be paid directly to the relevant service provider at the discretion of Zestlife.

Name and surname of account holder

Identity number of account holder

Bank name | Branch Code

Account number | Account type

3. PATIENT DETAILS

Full names

Surname

Date of birth DD/MM/YYYY Identity number (Compulsory)

Relation to policy holder Self ☐ Spouse ☐ Child ☐ Adult dependent ☐

Reason for claim Illness ☐ Accident ☐ Child birth ☐

Was the procedure planned and scheduled? **Please tick box** Yes ☐ No ☐

Was the procedure an emergency admission? **Please tick box** Yes ☐ No ☐

Was the procedure an elective procedure? **Please tick box** Yes ☐ No ☐

Was the procedure due to an illness or medical condition? **Please tick box** Yes ☐ No ☐

Date admitted to hospital DD/MM/YYYY Date discharged from hospital DD/MM/YYYY

Name of hospital/day clinic

Description of treatment received

To be completed ONLY if you have held the policy for less than 12 months:

When did the medical condition leading to your claim first occur? DD/MM/YYYY

Date of first consultation with a doctor for this condition DD/MM/YYYY

Name and contact details of doctors/specialists

	Name	Telephone number
General practitioner/house doctor		
Treating doctor		
Doctor who made the diagnosis		

Details of any medical treatment or consultations received in the 12 months prior to the cover start date

To be completed ONLY if the procedure was due to an accident as indicated above:

Date of accident DD/MM/YYYY

Details of accident

4. TYPE OF GAP CLAIM - PLEASE TICK THE BOXES WHICH CORRESPOND WITH WHAT YOU ARE CLAIMING FOR. YOU ONLY NEED TO COMPLETE THE SECTIONS THAT ARE RELEVANT TO YOUR CLAIM.

Medical practitioner cost shortfalls ☐ *Complete section A*

Internal prosthesis shortfall ☐ *Complete section A*

Accident tooth fracture benefit ☐ *Complete section B*

Benefit for first time cancer ☐ *Complete section D*

Oncology treatment 20%/25% co-payment ☐ *Complete section E*

Co-payment/deductible ☐ *Complete section A*

Casualty facility shortfalls ☐ *Complete section A*

Extended dentistry benefit ☐ *Complete section C*

Extended cancer benefit ☐ *Complete section D*

Non-affected breast reconstructive benefit ☐ *Complete section F*

Please request a special claim form if you want to claim for:

- Accidental death or disability Medical Premium Waiver benefit.
- Accidental death or disability benefit.
- Trauma counselling.

SECTION A - MEDICAL PRACTITIONER COST SHORTFALLS, CO-PAYMENT OR DEDUCTABLE, INTERNAL PROSTHESIS SHORTFALL OR CASUALTY FACILITY CLAIM

The procedure was In-hospital ☐ Out of hospital ☐ Casualty facility ☐

Date of service	Service providers (ie name of hospital, specialist, anaesthetist, doctor etc)	Total charged	Paid by medical scheme	Shortfall	Is the balance still outstanding to the Dr?
		R	R	R	
		R	R	R	
		R	R	R	
		R	R	R	

We can pay your claim faster if you fully complete the section above and provide all the listed documents below, at the outset when you submit this claim form. We can only start processing a claim once we have all the listed documents.

Documents to attach for a medical practitioner cost shortfalls, co-payment or deductible, internal prosthesis shortfall or casualty facility claim:

1. Detailed medical aid statements reflecting payment to all medical practitioners a shortfall is being claimed for and the co-payment or deductible. ☐
2. Medical aid pre-authorisation letter reflecting the co-payment or deductible. ☐
3. Medical practitioner accounts (ie doctor, specialists, anaesthetist, etc). ☐
4. Hospital account (first 4 pages and pages reflecting internal prosthesis costs). If a casualty facility claim, a copy of the casualty facility account. ☐
5. Proof that the co-payment or deductible was paid (receipt or credit card slip). ☐

SECTION B - ACCIDENTAL TOOTH FRACTURE BENEFIT

Number of teeth damaged ☐

Date of accident DD/MM/YYYY

Details of accident

We can pay your claim faster if you fully complete the section above and provide all the listed documents below, at the outset when you submit this claim form. We can only start processing a claim once we have all the listed documents.

Documents to attach for an accidental tooth facture benefit:

1. Dentist motivation of accidental injury and invoice reflecting damaged tooth number. ☐
2. If the patient is not the policyholder, a recent medical aid membership schedule reflecting that the patient is a dependant of the policyholder; or the detailed medical aid statement reflecting payment to the medical practitioner (dentist etc). ☐

SECTION C - EXTENDED DENTISTRY BENEFIT (ONLY AVAILABLE FOR POLICYHOLDERS WHO HAVE THIS BENEFIT)

Dentist name

Dentist practitioner number

Date of visit DD/MM/YYYY

Diagnosis	Possible treatment	Cover	Mark with X	Tooth numbers
Impacted wisdom tooth	Surgical tooth removal	R1 000 per tooth		
Periodontitis	Gum surgery	R1 750 per event		
Jaw fracture	Surgery	R16 500 per event		
Dental Emergency	Emergency Root Canal, temporary crown, temporary filling	R1 250 per event		
Accidental tooth fracture	Crown, splinting, bridge	R4 500 per tooth		
Severely decayed or damaged tooth	Crown	R3 250 per tooth		
Impaired function due to loss of teeth	Removable denture	R5 500 per jaw		
Occlusal instability	Implant or bridge	R10 000 per tooth		

We can pay your claim faster if you fully complete the section above and provide all the listed documents below, at the outset when you submit this claim form. We can only start processing a claim once we have all the listed documents.

Documents to attach for an Extended Dentistry benefit claim:

1. Dentist quote or invoice for the procedure.
2. Dentist X-ray for tooth.
3. If the patient is not the policyholder, a recent medical aid membership schedule reflecting that the patient is a dependant of the policyholder.
4. If a periodontitis claim then also a copy of the periodontitis treatment plan.

SECTION D - BENEFIT FOR FIRST TIME STAGE 2 CANCER DIAGNOSIS AND EXTENDED CANCER BENEFIT

Give full details of type of cancer

Name of doctor who made the diagnosis

Telephone number

Date of diagnosis DD/MM/YYYY

Is this a first time cancer diagnosis? Yes No

We can pay your claim faster if you fully complete the section above and provide all the listed documents below, at the outset when you submit this claim form. We can only start processing a claim once we have all the listed documents.

Documents to attach for a benefit for first time cancer diagnosis and Extended Cancer benefit claim:

1. Medical reports to be completed by medical practitioner (refer to the form on the last page of this document).
2. Histology reports and test results.
3. If the patient is not the policyholder, a recent medical aid membership schedule reflecting that the patient is a dependant of the policyholder.
4. Proof that the patient is registered on the medical aid's oncology programme.

SECTION E - ONCOLOGY TREATMENT PROGRAMME CO-PAYMENT

Give full details of type of cancer

Treating doctor

Telephone number

Date of diagnosis DD/MM/YYYY

Date of service	Service providers (ie name of hospital, specialist, anaesthetist, doctor etc)	Total charged	Paid by medical scheme	Co-payment
		R	R	R
		R	R	R
		R	R	R

We can pay your claim faster if you fully complete the section above and provide all the listed documents below, at the outset when you submit this claim form. We can only start processing a claim once we have all the listed documents.

Documents to attach for an oncology treatment programme co-payment:

1. Treatment plan.
2. Detailed medical aid statements reflecting payment to all medical practitioners a shortfall is being claimed for.
3. Medical practitioner accounts (ie doctor, specialists, anaesthetist, etc).

SECTION F - NON-AFFECTED BREAST RECONSTRUCTION BENEFIT

Date of mastectomy procedure DD/MM/YYYY

Date of service	Service providers (ie name of hospital, specialist, anaesthetist, doctor etc)	Total charged	Paid by medical scheme	Shortfall
		R	R	R
		R	R	R
		R	R	R

We can pay your claim faster if you fully complete the section above and provide all the listed documents below, at the outset when you submit this claim form. We can only start processing a claim once we have all the listed documents.

Documents to attach for a Non-affected breast reconstruction benefit:

1. Medical reports supporting the illness as well as copies of any relevant test results.
2. Proof of the single mastectomy of the affected breast due to cancer – a copy of the histopathology report.
3. Medical aid pre-authorisation letter.
4. Detailed medical aid statement reflecting payment to all medical practitioners a shortfall is being claimed for and the co-payment or deductible.
5. Medical practitioner accounts (ie doctor, specialists, anaesthetist, etc).
6. Hospital account (full account).

SECTION G: PROCESSING OF PERSONAL INFORMATION IN TERMS OF THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013

Your privacy is of utmost importance to Us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

You hereby agree to give honest, accurate and up-to-date Personal Information which may be used for the following reasons:

1. to establish and verify your identity in terms of the Applicable Laws;
2. to enable Us to fulfil our obligations in terms of this Claim;
3. to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
4. reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share your information for further processing with the following third parties, which third parties have an obligation to keep your Personal Information secure and confidential:

1. Payment processing service providers, merchants, banks and other persons that assist with the processing of any benefit payable;
2. Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime;
3. Regulatory authorities, industry ombudsmen, governmental departments, local and international tax authorities, and other persons that we, in accordance with the Applicable Laws, are required to share your Personal Information with; and
4. Credit Bureau's.

You acknowledge that any Personal Information supplied to Us in terms of this Claim is provided according to the Applicable Laws. Unless consented to by yourself, We will not sell, exchange, transfer, rent or otherwise make available your Personal Information to any other parties and you indemnify Us from any claims resulting from disclosures made with your consent.

You understand that if We have utilised your Personal Information contrary to the Applicable Laws, you have the right to lodge a complaint with Guardrisk within 10 (ten) days. Should Guardrisk not resolve the complaint to your satisfaction, you have the right to escalate the complaint to the Information Regulator.

MEDICAL REPORT FOR FIRST TIME STAGE 2 CANCER DIAGNOSIS BENEFIT

THE BELOW FORM IS ONLY NEEDED IF YOU ARE CLAIMING FOR THE CANCER FOR THE FIRST TIME STAGE 2 CANCER BENEFIT

To be completed by the patient's attending Medical Practitioner only

Full names of patient				
When were you first consulted by the patient in connection with his/her condition?		On what date was the patient diagnosed with cancer?		
Is this the patient's first diagnosis of any type of cancer ?	Yes	No	If no, when was the patient first diagnosed with cancer?	
Please provide details of any previous diagnosis of cancer				
Please provide full details of current diagnosis of cancer and ICD10 code				
If the cancer staging has progressed since the initial diagnosis, please provide the date the progression was confirmed.	DD/MM/YYYY			

Please clarify the severity of the current diagnosis	**Stage**					
	1	2	3	4	Local	Regional	Benign	Malignant
Please provide full details of oncology treatment plan								

Medical Practitioner Declaration

I hereby certify that the information provided above is true and correct in every respect.	
Name	
Qualifications	
Physical Address	
Telephone No	
Practice No	

Signed at _____ on this _____ day of _____ 20 _____

Medical Practitioner Signature _____