Stratum Benefits

2022 CLAIM FORM | FIRST-TIME CANCER DIAGNOSIS BENEFIT

1. YOUR PROFILE

PRINCIPAL INSURED DETAILS

Title | Name

Surname

ID/ Passport | Contact Numbers | or

Email Address

PATIENT DETAILS

◯ Please indicate if the patient is the principal insured, in which case the below details aren't required.

Title | Name

Surname | ID/Passport

Medical Aid | Medical Aid No.

Medical Aid Plan

2. MEDICAL HISTORY (For your treating Healthcare Provider to complete)

Date cancer was diagnosed – – | Type of cancer diagnosed (ICD10 Code)

Is this the first cancer ever diagnosed in the patient's lifetime? ◯ Yes ◯ No | If "No", confirm the date when cancer was diagnosed the first time – –

If "No", provide more information about the cancer that was previously diagnosed

Is the most recent diagnosed cancer in remission? ◯ Yes ◯ No | If "Yes", confirm the remission date – –

Confirm the following details regarding the cancer **currently** being treated:

Neoplasm is: ◯ Benign ◯ Malignant | Stage of cancer: ◯ Stage 1 ◯ Stage 2 ◯ Stage 3 ◯ Stage 4

Have cancerous cells invaded surrounding or underlying tissue? ◯ Yes ◯ No

Have cancerous cells spread from where it started to other parts of the body (metastasized)? ◯ Yes ◯ No

Is the patient registered on a medical aid oncology programme / treatment plan? ◯ Yes ◯ No

3. HEALTHCARE PROVIDER DECLARATION

As the Healthcare Provider who's treating/treated the patient, I hereby declare that the information provided is true and correct.

Healthcare Provider Name

Practice Number | Discipline

Practice Stamp

4. YOUR CLAIM REIMBURSEMENT PROFILE

The approved claim amount will be paid into the bank account number provided. We don't accept any responsibility or liability for a claim payment made into an incorrect bank account.

Bank | Account Number

Account Holder

Account Type
◯ Cheque ◯ Savings

Account Holder Signature

5. AUTHORISATION & DECLARATION ACCEPTANCE

I declare that the details and supporting documents submitted are true and correct. I understand that non-disclosure or false representation may result in the rejection of any claim and/or the cancellation of cover.

I hereby authorise my medical aid and healthcare providers, where applicable, to provide Stratum Benefits or their authorised representatives with any information that they need to assess my claim.

Principal Insured Signature | Date – –

Email **yourclaim@stratumbenefits.co.za**
Please enquire if you've not received feedback within **10 working days** from submitting the Claim Form