Abelard
UNDERWRITING AGENCY

GAP COVER CLAIMS NOTIFICATION FORM

This form is required in order for the Insurers to assess a possible claim. Completion of this form by the Insured or an Insured Person does not in any way limit liability.

Only once we have received a fully completed claim form, Doctors invoices and Medical Aid statements, will we be able to assess the incident being claimed for.

Any cost incurred in the completion of this form will be the responsibility of the Insured or the Insured Person.

A – General				
Insurer:	Abelard Underwriting Agency on behalf of Guardrisk Insurance Company Limited			
Name of Employer:				
Policy Number:				
B – Details of the Employer, Principle Member and Claimant				
Full Name of Principal Member:				
Date Employed:				
Full Name of Claimant:				
Date of Birth:			Occupation:	
Addresses:	***Residential:***		***Postal:***	
Contact Numbers:	***Office:***		***Cell:***	
Identity Number:			Date of Birth:	
Name of Medical Scheme:				
Medical Scheme Number:			Scheme Option:	
C – Details of the Accident/Hospitalisation				
Dates of Hospitalisation:	Admission:		Discharge:	
Date of Accident:			Time of Accident:	
Place of Accident:				

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C – Details of the Accident/Hospitalisation	
Provide a detailed description of the Hospitalisation / Accident:	

Please attach copies of all accounts received from the Hospital and Doctors together with Medical Aid Statement reflecting payments

Kindly note that the claim is only valid for the period that you were in Hospital.

D - Banking Details for Refunds			
Account Holder:			
Bank:			
Branch:		Branch Code:	
Account Number:		Account Type:	

For office use only

Gap Cover Claim: Benefit Calculation Form

Name of Hospital:	
Date of Admission:	
Date Discharged:	

Names of Doctors:	*Practice Codes:*

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Procedure:	***Code:***	***Tariff:***	***Cost:***

Totals Claims:		***Notes:***
Less Tariff:		
Other:		
Total Due:		

Claim submitted to Abelard: ……

Processed by: ……..……

Checked by: ……..……..

Date: ……..……..

Amount Due: ……..……..

Comments: _____

Client Queries: _____

File Closed: _____