medway
expect much more

Medway Gap CLAIM FORM

SECTION 1 PERSONAL PARTICULARS OF PRINCIPAL INSURED

Surname: Du Plessis
Title: Mrs
First Name(s): Catharina Johanna Susanna
ID No: 6501100158089
Date of Birth: 10011965
Telephone (H): (/)
Telephone (W): (/)
Cell No: 083 601 2552
Email Address: rianaduplessis65@gmail.com
Postal Address: 61 Jurgens ave, Strubenvale, Springs, Postal Code 1559
Physical Address: 61 Jurgens ave, Strubenvale, Springs, Postal Code 1559
Medway Policy No: MED0169547
Medical Aid: GEMS
Medical Aid Option: EMERALD
Membership No: 0019214158

SECTION 2 PATIENT DETAILS *(If different to Principal Insured)*

Surname: Du Plessis
Title: Mrs
First Names: Catharina Johanna Susanna
ID Number: 6501100158089
Date of Birth: 10011965
Relationship to Principal Member: Principal Member
Occupation: N/A
General Practitioner / Referring Dr:
Doctor's Tel No: ( )

SECTION 3 TYPE OF CLAIM *(One claim form per claim type)*

- [x] Gap
- [ ] Sub-Limit
- [ ] Co-Payment
- [ ] Consumable
- [ ] Sub-Limit Lite
- [ ] Appliance Benefit
- [ ] Non DSP Hospital Co-Payment

SECTION 4 DOCUMENTS ATTACHED *(A claim cannot be processed if ANY one of these requirements are not included)*

- [x] Hospital Account
- [x] All related Doctors' and/or Specialists' Accounts (not applicable for Co-payment)
- [x] Related detailed Medical Aid Statement (no summary statements will be accepted)
- [ ] Proof that Dependant over 21 years is a full-time student or is disabled (if applicable to patient)
- [ ] Proof of Payment for Co-payment Claim (Procedural or Non DSP)
- [ ] 12 months Medical Aid Statements
  (if you are claiming within the first 12 months of the policy commencement date and if the condition existed prior to the policy commencement)
- [ ] Hospital Authorisation
- [ ] Attach previous membership certificate of Gap Cover (if applicable)

SECTION 5 HOSPITALISATION DETAILS

Does this claim arise from treatment received whilst you were in a hospital /clinic/day admission? Yes ☑ No ☐ **If "YES", please complete the following:**

Diagnosis: Ablation had to be done.

Hospital Name: Netcare Alberton Telephone: (011) 742 3000

Date of Admission: 29/01/2025 Date Discharged: 31/01/2025

Name of Attending Doctor: Dr. V. Mtwesi Practice No: 0180030735388

Doctors Contact No: (Netcare Alberton Hospital)

Reason for Hospitalisation: Abnormal heartrate - spikes very high (60 → 180 eg without warning) + these "episodes" happened constantly causing problems breathing (needed oxygen). Heartrate had to be monitored all the time → ⊛ SUPRAVENTRICULAR TACHYCARDIA

Date of Service	Amount Charged	Name of Service Provider	Amount Paid by Medical Aid	Shortfall
29/01/2026	R 11 880.80	Dr Kgokong S Pooke	R 6 920.00	R 4960.80
		Total Claim Amount	R 4960.00	

Have you paid anything to any one of the service providers? Yes ☐ No ☑ **Were you offered a discount by any of the service providers?** Yes ☐ No ☑

If 'Yes' to either, please provide details: N/A

SECTION 6 PAYMENT INSTRUCTIONS *(Benefits will be paid by EFT into the stipulated bank account below)*

Account Holders Name: Pay Provider directly Bank:

Account Number: Branch:

Branch Code: Account Type ☐ Current ☐ Transmission ☐ Savings

(No credit card accounts accepted)

Signature of Account Holder: Date:

Signature of Principal Insured (if different from Account Holder): Date:

Click the Sign icon in the Adobe Acrobat Reader toolbar and follow the prompts to add your signature.

The company will not be liable for the loss of funds due to the provision of incorrect bank details by the member.

SECTION 7 GENERAL

Were you aware at the time of applying for the this Policy, that you would require hospitalisation for this medical condition?

Yes ☐ No ☒

Did you disclose this medical condition on your application form?

Yes ☐ No ☒

SECTION 8 PERSONAL INFORMATION ACKNOWLEDGEMENT

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 Bureaus.

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.

Signed by the Principal Insured / Beneficiary BduPlessis Date 20250428

Click the Sign icon in the Adobe Acrobat Reader toolbar and follow the prompts to add your signature.

SECTION 9 DECLARATION

1. I hereby declare and warrant that the information given in this claim form is in every respect complete and true to the best of my knowledge.
2. I authorise the Insurers and/or their representatives to contact any medical practitioner, hospital or any other applicable parties to provide information they may require relating to my medical history and the injury or illness to which this claim relates. I agree that this consent shall remain in force at all times, and that a copy of this declaration shall be accepted as the original.
3. I understand that the information provided in relation to this claim may be shared with other insurers for the purposes of processing this claim and eliminating insurance fraud.
4. I understand that the issue of this claim form does not imply an admission of liability by the company and that only a fully completed and signed claim form, submitted within the stipulated timeframes, can receive any further attention.
5. I authorise the administrators to pay the claimed monies into the bank account of the Principal Insured (Could be joint account with Spouse) or Legal Representative of the Principal Insured as detailed in this application. (Authorisation Letter will be required if bank details differ from those of the Principal Insured that we have on record).
6. I authorise the administrators to pay the benefits, if applicable, to my beneficiary.
7. I accept that Medway may use WhatsApp as a form of communication and I agree to keep my cell number up-to-date with Medway.
8. I understand that the insurer may settle the outstanding/claimed amount directly with the service provider and that I will be advised in writing when this transpires.

Signed by the Principal Insured BduPlessis Date 20250428

Click the Sign icon in the Adobe Acrobat Reader toolbar and follow the prompts to add your signature.

IMPORTANT INFORMATION: Please read carefully before submitting your claim

1. Ensure that ALL the relevant sections of this claim form are complete.
2. Ensure that you have attached ALL the relevant supporting documentation.
3. Please note that Medway and Manage Plus cannot request medical aid statements and other required documents on your behalf.
4. An incomplete claim cannot be processed until such time as ALL requirements are met.
5. Once we have all required documentation, your claim will be processed within 10 working days.
6. Should this claim not be intimated within 6 months from incident date, with the outstanding documentation being received within 12 month from same, you will need to include a motivation justifying the extended period taken to submit this claim.
7. Should any outstanding amounts be amended by the service providers prior to the claim settlement, kindly ensure that you submit the updated account to us to reflect the changes.

Please email your completed claim forms to ✉ medwayclaims@ambledown.co.za and copy in claims@medway.co.za.
Should you have any enquiries, kindly contact Medway on ✆ 0860 633 929 (MEDWAY) or send a WhatsApp message to ✆ +27 65 524 5279.
You can also download the Medway App from the Google Play Store or Apple App Store and use it to request us to contact you.