HEALTH / GAP COVER CLAIM FORM | 2024

CompliMed®

...for the GAP in your medical aid

Insurer:
Lombard Insurance Company Limited
(Reg. No. 1990/001253/06) FSP no. 1596

Risk and Underwriting Managers:
Turnberry Management Risk Solutions (Pty) Ltd
(Reg no : 2007/026488/07) FSP no. 36571

Policy Number:

Telephone: 032 815 2969

A. DOCUMENTS REQUIRED

Turnberry the Administrator must be notified of any claim within five ((5) months calculated from the date of treatment and all documentation must be received within 90 days from the date outstanding documentation is requested by Turnberry.
Please ensure that all documents requested below accompany your completed Claim Form to avoid unnecessary delays.

- Completed Claim Form
- Copy of your service provider's/doctor's account reflecting all transactions relating to the claim
- Copy of the Hospital account
- Copy of your Medical Scheme's statement reflecting all transactions relating to the claim/treatment. Unfortunately an "acknowledge of payment" issued by your Medical Scheme does not provide the necessary information.

Please note, based on the information provided the Administrator may need to request additional information.

Please complete and return by email to: claims@turnberry.co.za

B. DETAILS OF PRINCIPAL INSURED

Title:
Gender: ○ Male ○ Female
ID Number:
Date of Birth:
Initials:
First Name:
Surname:
Postal Addresses:
Code:
Work Tel No.
Cellular Tel No.
Home Tel No.
Email:

C. MEDICAL AID DETAILS

Company	Option	Medical Aid Number

D. DETAILS OF PATIENT

Surname:
Title:
First Names:
ID Number (If not available Date of Birth):
Referring Doctor/GP details (name & contact number):

E. CLAIMS FOR CANCER ONLY

Has the patient received treatment, consulted with a medical service provider and/or received advice in relation to the condition in the last 12 months?

◯ Yes ◯ No

If so, please provide the date(s) of the consultation(s).

F. PAYMENT OF CLAIMS

Turnberry the Administrator reserves the right to negotiate a discounted rate with your relevant medical service provider(s) in exchange for direct payment to them.

Please advise if you have paid your medical service provider(s)? ◯ Yes ◯ No

G. BANK DETAILS OF PRINCIPAL INSURED

Accountholder's Name	
Name of Bank	
Branch Code	
Account Number	

Type of account: CHEQUE ◯ SAVINGS ◯ TRANSMISSION ◯

I declare that the banking details provided are correct, failing which, Turnberry the Administrator is not liable for any losses, charges and expenses. I accept that it is my responsibility to notify the Administrator timeously of any changes in my banking details. The indemnity payment may give rise to a potential Output Tax liability under section 7(1)(a) read with section 8(8) of the Value Added Tax Act.

Signature of Principal Insured: _____ Date:

H. DECLARATION BY THE PRINCIPAL INSURED

I warrant that I am legally entitled to receive the benefits in terms of the said policy. Turnberry the Administrator shall not be liable for payment if the cause of accident/illness is related to an exception detailed in the policy document and any endorsements thereto. In support of a claim in terms of the said policy, I declare that all statements and answers which may now or at any time be given in connection with this claim, whether in my handwriting or not, are true and complete. I understand that any misstatement or non-disclosure, which materially affects the assessment of this claim, will entitle the Administrator to declare this claim null and void. I hereby authorise the patient's Medical Scheme, any Hospital, medical service provider or any other person who has attended to or examined the patient, to furnish to the Administrator or the Administrator's authorised representative any information with respect to any illness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

Should any benefit be paid by the Administrator and subsequently settled, in whole or part, by the patient's Medical Scheme or the medical service provider/s reduced the amount they have charged, the amount of the overpayment will be refunded to the Administrator.

Signature: _____ Date: