GAP COVER CLAIM FORM

sizwe medical fund
Caring for the Health of the Nation

To be submitted to Fund within three months of treatment date.

NAME _____ MEMBERSHIP NUMBER [ ][ ][ ]–[ ][ ][ ][ ][ ][ ][ ]–[ ]

DATE OF BIRTH OF MEMBER [D][D][M][M][Y][Y][Y][Y]

NAME OF PATIENT _____

DATE OF BIRTH OF PATIENT [D][D][M][M][Y][Y][Y][Y]

RELATIONSHIP TO MEMBER _____

MEMBER'S BUSINESS TELEPHONE NUMBER ([ ][ ][ ]) [ ][ ][ ][ ][ ][ ][ ]

MEMBER'S CELL NUMBER ([ ][ ][ ]) [ ][ ][ ][ ][ ][ ][ ]

MEMBER'S ADDRESS _____

EMAIL ADDRESS _____

NAME OF EMPLOYER _____

DETAILS OF ACCOUNTS

PROVIDER	PROVIDER PRACTICE NO.	TREATMENT DATES	ACCOUNT AMOUNT

NB: please attach copies of all claims

BANK _____ BANK ACCOUNT NUMBER _____

BRANCH _____ BRANCH CODE _____

NAME OF ACCOUNT HOLDER _____

ACCOUNT TYPE _____

SIGNED AT _____ DATE [D][D][M][M][Y][Y][Y][Y]

SIGNATURE _____

Sizwe Medical Fund is administered by Sechaba Medical Solutions

2010/GC/2

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