Turnberry GAP COVER
NAVIGATING THE WAY
(FSP no. 36571)

LOMBARD
(FSP no.1596)

HEALTH/ GAP COVER CLAIM FORM 2024

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

Telephone: 011 677 9891
Fax: 086 676 0777
Physical Address: 4 Osborne Lane, Bedfordview, 2007
Postal Address: Private Bag X2, Gardenview, 2047

Policy Number:

Please complete and return by fax to: **086 676 0777** or 086 673 4224 | Email to: claims@turnberry.co.za

A. DOCUMENTS REQUIRED

Turnberry must be notified in writing of any claim within five (5) months calculated from the date of treatment. Outstanding documentation needs to be submitted 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 (for co-payments, sub-limits, casualty benefit and shortfalls for pathology and radiology)
- 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 Turnberry may need to request additional information.

B. DETAILS OF PRINCIPAL INSURED PERSON

Title: | Gender: ◯ Male ◯ Female

ID Number: | Date of Birth:

Initials: | First Name:

Surname:

Postal Address:

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

F.

Turnberry 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 is not liable for any losses, charges and expenses. I accept that it is my responsibility to notify Turnberry 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 shall not be liable for payment if the cause of accident/illness is related to an exception detailed in the Policy Schedule 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 Turnberry 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 Turnberry or Turnberry'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 Turnberry and subsequently settled, in whole or part, by the patient's medical aid or the medical service provider reduced the amount they have charged, the amount of the overpayment will be refunded to Turnberry. I acknowledge and accept that for the purposes of assessing and processing this claim, effectively administering your policy and dealing with all other matters related thereto, Turnberry Management Risk Solutions may process and share my information with Lombard Insurance Company Limited, its third party service providers and/or agents who will assist in the investigation of your claim and/or the administration of your policy. During this process, my information may also be shared with your medical scheme.

On my own behalf, and on behalf of any person(s) I represent herein, I hereby consent to such information being disclosed for the aforementioned purposes with the aforementioned parties. I also acknowledge that the insurance information provided by me may be stored in a shared database and used as set out above.

Turnberry Management Risk Solutions, Lombard Insurance Company Limited and its associated parties undertake to insure that your personal information is protected as required under the Protection of Personal Information Act 4 of 2013, as amended, and that your personal information will not be shared with third parties for any purpose or in any format whatsoever, apart from the sharing of information as contemplated in the preceding paragraph.

Signature: _____ Date: _____