NEDBANK INSURANCE

2024

NEDGROUP MEDICAL GAP INFORMATION GUIDE

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WHAT IS GAP COVER
& WHY YOU NEED IT

Nedbank offers a comprehensive Gap Cover solution tailored for the unique requirements of the South African healthcare market. Gap cover is an essential complement to all medical schemes, and is available to employees as part of their personal healthcare portfolio. Nedgroup Gap cover has a highly specialised service team to ensure that employees receivefocused responses.

This policy does not discriminate based on race, age, gender, marital status, ethical or social origin, sexual orientation, pregnancy, disability, state of health, geographical location or any other means. We do however charge a different premium based on your age at the time of inception and apply waiting periods, if applicable.

Disclaimer:
This is not a substitute for a medical scheme membership and the cover is not the same as that of a medical scheme. This is a Short-term Insurance Accident and Health policy in terms of the Short-term Insurance Act 53 of 1998. Terms and conditions apply.

DID YOU KNOW?

You are under no obligation to divulge any information about your personal insurance portfolio to any provider or outside party, even if the hospital or specialist requests it.

WHO IS COVERED?

We cover policyholders and beneficiaries of all ages. The benchmark for premium determinationis based on whether you join as an individual or as a family, and the prospective policyholder's age at the inception of the policy according to the following three age bands:

- **18 - 54** years
- **55 - 64** years
- **65** years or older.

We will cover you and all the dependants registered on your medical scheme on one policy.

If you belong to **2** different medical schemes, or medical scheme options, we will cover two adults (i.e. the policyholder and one other adult dependant, if applicable) and all child dependants on one policy.

A child is considered to be a child dependant up to the age of **21**, however cover can be extended to the age of **27** for full-time students. Documented proof of full-time study enrolment is required to verify a dependant over the age of **21**, or by providing the Certificate of Membership (COM) from your medical scheme confirming that the dependant is still on the same medical scheme.

EXAMPLES OF
CLAIMS PAID IN 2023

Confinement claim:
Delivery by Caesarean section

Gynaecologist charged:
R29 500

Medical Scheme Paid:
R4 177.70

Sirago Paid:
R25 322.30

Member paid:
R0.00

Heart disease claim:
Angiogram

Anaesthesist Charged:
R20 531.70

Medical Scheme Paid:
R5 789.48

Sirago Paid:
R14 742.22

Surgeon charged:
R28 942.10

Medical Scheme Paid:
R9 924.20

Sirago Paid:
R19 017.90

Member paid:
R0.00

Total Gap Cover paid:
R33 760.12

Orthopaedic Admission via Emergency Room:
Joint Ligament Reconstruction

Orthopaedic Surgeon Charged: **R35 163.55**

Medical Scheme Paid:
R11 553.00

Sirago Paid:
R23 610.55

Member paid:
R0.00

Out-of-Hospital Specialist Consultation claim

Dermatologist Charged:
R2 540.00

Medical Scheme Paid:
R1252.10

Sirago Paid:
R1 287.90

Member paid:
R0.00

Cancer claim:
Breast Reconstructive Surgery (Affected Breast)

Plastic Surgeon charged:
R33 908.95

Medical Scheme Paid:
R13 248.20

Sirago Paid:
R20 660.75

Member paid:
R0.00

NEDGROUP MEDICAL GAP COVER

Age Limit: none
Overall Annual Limit (OAL) Per Beneficiary: R201 000

	18 - 54	55 - 64	65+
Individual	R176	R214	R270
Family	R260	R322	R398

Premiums are reviewed and may be adjusted annually.

The following benefit categories form part of the aggregated OAL of **R201 000.**

SCAN ME

In-Hospital Benefits

GAP COVER
This covers the difference (the shortfall or the gap) between what the medical scheme pays and the doctors and specialists charge in hospital. We settle claims at **500%** above scheme rate to a maximum of **600%** above medical scheme rate or at the stated benefit value. For Robotic surgery claims that are reflected on the hospital account, we will cover up to a sub-limit of **R25 000** per policy, up to **R18 000** per claim. We will also cover the shortfall on claims for BMI (Body Mass Index) codes 0018 and 0019 only. **Subject to the OAL.**

CO-PAYMENTS AND CO-PAYMENTS CHARGED AS A PERCENTAGE
Co-payment cover is for the co-payments (including co-payments expressed as a percentage), excesses, or deductibles as stipulated, or imposed by a medical scheme, for specified procedures, cover for hospital admission fees, or surgical procedures. The co-payment must be part of your medical scheme rules which will be highlighted on the authorisation for your procedure.
Subject to the OAL.

Refer to the Cancer Co-payment benefit for claims related to cancer.

PENALTY FEE CO-PAYMENTS
When you choose to use a hospital that is not on your medical scheme's network, you may have to pay a stated amount or percentage of the accounts as specified by your medical scheme rules.

This benefit has a sub-limit of **R14 000** per claim per beneficiary per policy, irrespective of whether a rand amount or percentage penalty fee is charged by the medical scheme. Note that this is for the voluntary use of a non-designated service provider or network hospital and includes the use of a partial cover network hospital. Co-payments for administration charges are specifically excluded from cover on this option.
Subject to the OAL.

DAY HOSPITAL/CLINIC AND/OR IN-ROOM SURGICAL PROCEDURES COVER
This benefit will cover the shortfall for any day hospital, clinic, or in-room procedures including acute hospitals if a policyholder elects to have the treatment that would normally be performed in hospital, done in a day hospital, clinic, or in a doctor's room by a registered medical professional.
Subject to the OAL.

PRESCRIBED MINIMUM BENEFIT (PMB) COVER
Prescribed Minimum Benefits (PMB) give all scheme members access to certain minimum health benefits, regardless of your medical scheme option. Medical schemes are required to pay the full cost of diagnosis and treatment of a defined list of PMB medical conditions.

PMB Cover on this policy is only for the shortfalls resulting from the use of a non-designated service provider for a planned PMB procedure. This is not applicable in the event of an emergency. In the event of an emergency, PMB protocols should be adhered to. **Subject to the OAL.**

HOSPITAL ACCOUNT SHORTFALLS
This benefit will cover any charges, like consumables or take-home medication, on the hospital account that the medical scheme has not paid. We also cover take-home medication that the medical scheme has not paid from risk and the cost of upgrading to a private ward up to the benefit amount.

We pay up to **R6 500** per policy, **R1 350** per claim. A **R2 000** sub-limit is applicable to private room upgrades. **Subject to the OAL.**

SUB-LIMIT ENHANCER BENEFIT
This benefit has a sub-limit of **R26 500** per claim, per policy.

Medical scheme benefits available on the medical scheme option for MRI & CT scans, cochlear implants, intraocular lenses, internal prostheses only, and Transcatheter Aortic Valve Implantation (TAVI) procedure valves. When you exceed your medical scheme benefit limit during the time of the event, resulting in a shortfall or "gap", we will pay the shortfall depending on the Gap option you are on.

If you claim and your medical scheme limit has been reached at the time of the event, meaning it was used up before the claim event, and your medical scheme does not contribute anything towards this benefit, we will also not pay. **Subject to the OAL.**

Refer to the Cancer Co-payment benefit for claims related to cancer.

STEP-DOWN
There is a sub-limit of **R11 000** per policy if your medical scheme provides benefits for rehabilitation as an in-patient in a step-down or sub-acute facility.

Cover will be provided for ongoing treatments, resulting from an accident, stroke, or cancer treatment, when your medical scheme benefit limits have been reached. **Subject to the OAL.**

For all terms and conditions, benefits, limitations, and exclusions go to https://sirago.co.za/nedgroupgap

Out-Of-Hospital Benefits

PRIMARY CARE
This benefit covers you for the shortfall on the consultation fee only when your medical scheme pays their scheme agreed rate up to **R5 000** per policy, and **R500** per claim.

This includes the fees for:
- GP Consultations
- Dental Consultations
- Alternative therapist consultations (Chiropractors, Physiotherapists, Biokineticists, occupational therapists, Homeopaths, and Audiologists – if covered by the medical scheme option you are on.)
  Subject to the OAL.

This specifically excludes any other related charges during the consultation for services rendered where there are charges applicable.

IN-ROOM/DAY-TO-DAY SPECIALIST CONSULTATION FEE
This benefit covers the shortfall on the consultation at a specialist outside of hospital (excluding Psychiatrist and Psychologist) up to **R6 500** per policy, and **R1 350** per claim, **3** claims per beneficiary. This benefit is only applicable to consultation codes 0190, 0191, and 0192. The medical scheme needs to make at least partial payment towards the consultation code mentioned above. **Subject to the OAL.**

EMERGENCY ROOM COVER (Ref 1, 2, 3)
There is a sub-limit of **R12 000** for all Emergency Room Cover. This benefit covers an emergency at any registered emergency room, hospital, or casualty facility when you require immediate medical treatment due to an accident and trauma, or illness.

We will cover a general practitioner (GP)'s consultation rooms if no other emergency facility is available within a **30** km radius.

Ambulance costs are not covered by this benefit.

1. ACCIDENT & TRAUMA BENEFIT
All costs related to the accident/trauma event will be covered, whether you are liable to pay the costs out of your own pocket or if your medical scheme pays from your savings.

2. ILLNESS BENEFIT
All costs related to the emergency illness event will be covered and paid up to **R2 500** of the sub-limit, if you are liable to pay the costs out of your own pocket, or if paid from your medical scheme savings.

This is applicable to any beneficiary **9** years and older who needs emergency treatment outside of normal consultation hours or treatment that can only be done in an emergency facility.

3. CHILD EMERGENCY ILLNESS BENEFIT
This benefit is applicable to children **8** years and younger who require emergency treatment for illness out of normal consultation hours or treatment that can only be done in an emergency room. All costs related to the event will be covered, whether you are liable to pay the costs from your own pocket or your medical scheme pays it from your savings account.

Out of normal consultation hours means 18h00 to 07h00 on Monday to Friday, and all of Saturday, Sunday, and South African public holidays. Subject to the OAL.

PREVENTATIVE CARE COVER
If your medical scheme option makes provision for preventative care, we will pay up to **R8 000** per policy, and up to **R1 250** per claim.

The following procedures or treatments are covered: Pap smear, cholesterol test, blood glucose test, flu vaccination, childhood immunisation (Department of Health Formulary) – up to the age of 12 years, bone-density scans, prostate-specific antigen tests, mammogram, and contraceptive implantation only.

Alternatively, if there is no benefit available at the time of claim, up to **R500** will be paid towards the following tests and treatments, **2** claims per policy:

- **Pap smear.**
- **Child Immunisations (Department of Health Formulary) – up to the age of 12 years.**
- **Mammogram.**
- **Bone density scans.**

APPLIANCE BENEFIT
We will pay up to **R7 000** per policy for the shortfall between the medical scheme benefit amount (if there is a rand limit) and the service provider account for the following appliances: **hearing aids, wheelchairs, continuous positive airway pressure (CPAP) machines, humidifiers, insulin pumps, glucometers, nebulisers, and Mirena devices.**

TRAUMA COUNSELLING
This benefit covers trauma counselling with a registered medical professional within the first 6 months after a traumatic event, such as but not limited to dread disease, hijacking, and/ or violent crime. We will pay up to **R8 000** per policy, and up to **R950** per claim.

Cancer Benefit

Cancer benefits apply if cancer treatments do not form part of the legislative PMB framework.

CANCER CO-PAYMENT BENEFIT
This benefit applies if your medical scheme cancer benefit **has been reached** and a **percentage co-payment is imposed**. This benefit incorporates co-payments for ongoing cancer-related treatments and biological drugs. Ongoing treatment must be in line with the registered treatment plan of your medical scheme to access this benefit.
Subject to the OAL.

CANCER BOOST BENEFIT
The Cancer Boost Benefit is applicable to policyholders whose medical scheme option has a **defined rand limit** for cancer treatment and the rand limit on the medical scheme has been reached. We will cover the costs of ongoing treatment in line with the medical scheme's registered treatment plan once the rand limit has been reached.
Subject to the OAL.

CANCER BREAST RECONSTRUCTION BENEFIT
After a mastectomy, we will cover up to **500%** above the medical scheme rate for the reconstructive surgery of the affected breast, if it is approved by your medical scheme. Up to **R27 500** will be paid for the reconstruction of the unaffected breast if there is no payment by the scheme. This benefit is only available within the first 18 months of the initial mastectomy. There is no benefit for any costs related to PMB services, treatments, or medical interventions, unless otherwise stated.

This benefit is available if the member was on Sirago at the time of the mastectomy or been on Sirago for a year after transferring from another Gap Provider. **Subject to the OAL.**

#DIDYOUKNOW

To add a dependant onto your policy, simply complete and submit the additional dependant form to applications@sirago.co.za - you can download it from the website.

Value-Added Benefits

The following benefits do not form part of the aggregated OAL of **R201 000.**

GAP COVER PREMIUM WAIVER
In the event of death or total permanent disability of the Sirago policyholder, we will keep the premiums for your policy as a credit for **6** months. This benefit may be claimed by the surviving spouse or adult dependent on the Sirago policy.

MEDICAL SCHEME PREMIUM WAIVER
Sirago will pay the rand amount of the medical scheme premium, not higher than **R5 250** per month for a **6**-month period. This will be paid to the beneficiary for the upkeep of the medical scheme contributions in event of death or total permanent disability of the Sirago policyholder and where all beneficiaries are linked to a single medical scheme. This benefit is only payable for the medical scheme that the policyholder was on if there is dual medical scheme membership.

ACCIDENTAL DEATH
This benefit will pay out for accidental death: at **R16 000** for the Sirago policyholder, **R11 000** for the adult dependant, and **R6 000** for child dependants.

INITIAL CANCER DIAGNOSIS (FIRST DIAGNOSIS)
This benefit will pay out a lump sum of **R27 500** per beneficiary in the event where you are diagnosed with malignant cancer from **stage 1** for the first time ever. Any cancer prior to inception of the policy or pre-existing cancer is excluded. Skin cancer is specifically excluded from cover on this policy, except malignant melanomas.

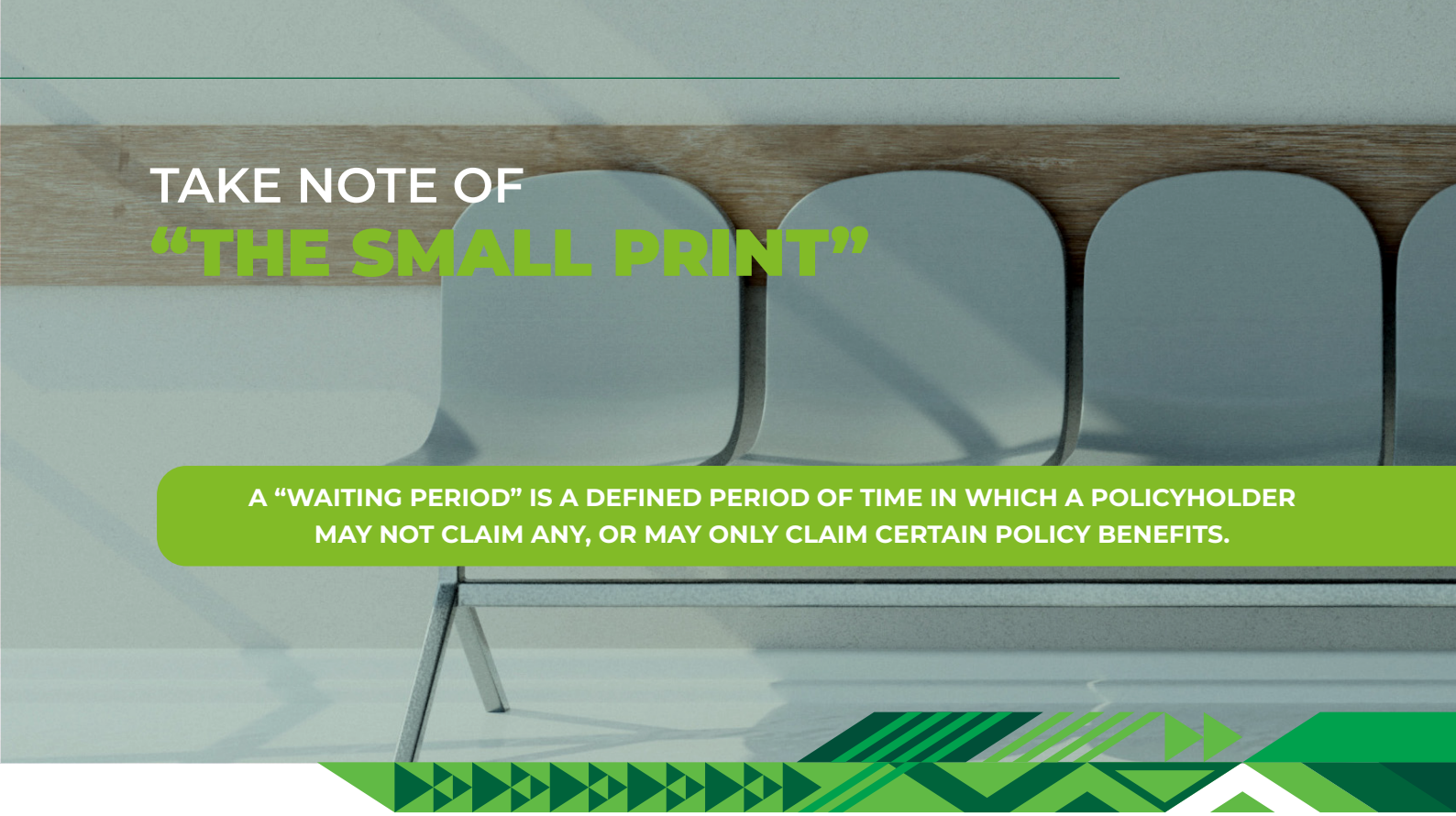
SIRA'GO BABY
Sirago will pay out a lump sum of **R2 000** to you, per newborn baby, when the baby is registered on your gap policy within **90** days of birth.

To register your newborn(s), simply fill out the additional dependant form and submit it to changes@sirago.co.za together with your baby's birth certificate.

SIRAGO MEDCARE - FREE MEDICAL SCHEME ALTERNATIVE DISPUTE RESOLUTION SERVICE (ADR)
This benefit gives you access to MedCare's free ADR service for all disputed **PMB claims exceeding R9 000**. You can also access the MedCare service for all claims **less than R9 000**, including all potential medical scheme disputes, at a **60%, 20%, and/or 15%** discounted rate depending on the required service. Your broker can also access this service on your behalf and will subsequently have access to the MedCare website: siragomedcare.co.za.

For all terms and conditions, benefits, limitations, and exclusions, please always refer to your Policy Wording, visit https://sirago.co.za, or contact your broker.

Please remember to use the full disclaimer with OMI on the back and front page.



TAKE NOTE OF "THE SMALL PRINT"

A "WAITING PERIOD" IS A DEFINED PERIOD OF TIME IN WHICH A POLICYHOLDER MAY NOT CLAIM ANY, OR MAY ONLY CLAIM CERTAIN POLICY BENEFITS.

GENERAL WAITING PERIODS

- A **3**-month general waiting period is applicable on any newly incepted policies and /or additional dependants to the current policy, except in the event of an accident.
- A **10**-month waiting period on pre-existing conditions, diseases or illness.

POLICY SPECIFIC WAITING PERIODS APPLICABLE TO CERTAIN PROCEDURES

- The following conditions are excluded within the first **6** months of the inception of the policy:
  - Myringotomy and grommets;
  - Adenoidectomy;
  - Tonsillectomy;
  - Hysterectomy (except if malignancy is proven);
  - Spinal, back, neck, and joint-related procedures (repairs, scopes, and joint replacement) except in the case of an accident. This includes treatments related to any and/or investigations such as MRI scans, CT scans, and scopes.
- **50%** of benefits will be paid on claims from month **7** to **10**.
- From month **11**, the policy benefits will be fully available, unless there are condition specific exclusions.

SPECIFIC WAITING PERIODS APPLICABLE TO CERTAIN BENEFIT CATEGORIES, AND CERTAIN CONDITIONS, AND/OR RELEVANT OPTIONS

- **10**-month waiting period for pregnancy and confinement.
- **6**-month waiting period on Total Permanent Disability and Premium Waivers.
- **3**-month waiting period on Initial Cancer Diagnosis and Accidental Death.
- **12**-month waiting period on all pre-existing cancer-related treatments.

TRANSFER OF COVER

- All waiting periods are waived if you have held cover for **12** months or longer with your current provider.
- If you are currently serving waiting periods with your current provider, the balance is applicable at Sirago.
- If you are transfering to a higher options, a **3**-month general waiting period is applied on all additional benefits

SIRAGO POLICY UPGRADES

- If the Sirago policyholder has held a policy for **12**-consecutive months and wants to upgrade to a higher option, all additional benefits will be subject to a **3**-month waiting period.
- If the Sirago policyholder has held a policy for less than **12**-consecutive months and wants to upgrade to a higher option, the difference between the balance of the waiting periods imposed will be applied, and a **3**-month waiting period on additional benefits.

IMPORTANT
SMALL PRINT CONTINUED...

EXCLUSIONS - WHAT SIRAGO DOES NOT PAY FOR

Sirago will not pay for any illness, condition, disease or injury, or the consequences or treatment resulting from or associated with:

- Benefits that your medical scheme excludes or does not pay for, or has not paid a portion of the claim, or if you have used up your whole benefit limit on the medical scheme.
- If there is no authorisation from the medical scheme and they do not pay, neither does Sirago.
- Sirago has certain stated benefits that are not related to claims from the medical scheme.
- The first **100%** of the medical scheme tariff or rate for any claim, unless it is a scheme-imposed co-payment charged as a rand amount or percentage of cost. The medical scheme should be responsible for the first **100%** or **200%** of the claim, according to your medical scheme option.
- Claims that exceed the limit of each benefit category.
- Out-patient or day-to-day treatment, consultations , investigations, or surgical procedures unless there is a specific benefit on your Sirago option.
- The cost of any experimental treatments and medication, both in and out of hospital are not covered.
- Any claim less than the minimum claim amount of **R100**.
- Claims for organ donations and recipients do not have any benefit entitlement.
- In the event that there were no benefits available from the scheme at the time of the procedure, Sirago will not provide any benefits in this regard.

GENERAL POLICY EXCLUSIONS

Sirago will not compensate you for any illness, condition, disease or injury, or the consequences or treatment resulting from or associated with:

- An event not covered by this policy and/or falling outside of the policy's intention.
- An event where pre-authorisation was not obtained from the medical scheme or where medical scheme rules were not adhered to.
- Any claim that must be paid in terms of alternate proclaimed legislation, such as the Compensation for Occupational Injuries Act 90 of 1993, and the Road Accident Fund Act 56 of 1996.
- Any dependant not noted on the policy on the incident date.
- Any pre-existing condition, disease, disorder, or illness, for the first **10** months. This will include any condition which existed before inception, whether diagnosed or not, or for which an insured person has sought or received medical advice, received treatment by a registered medical professional, or exhibited symptoms, before the actual inception of the policy.
- Any pre-existing cancer condition, disease, disorder, or illness, for the first **12** months. This will include any condition which existed before inception, whether diagnosed or not, or for which an insured person has sought or received medical advice, received treatment by a registered medical professional or exhibited symptoms before the actual inception of the policy.
- Breast reconstruction and breast reconstruction performed as a secondary or subsequent reconstruction, unless part of the benefit entitlement of your Sirago option.
- Intraocular lenses, unless part of the benefit entitlement of your Sirago option.
- Claims for regular or routine medical treatment or advice on an on-going basis, and routine physical examinations or procedures purely of a diagnostic nature, except as listed under the Preventative Care benefit.
- Any illness, injury, or consequence of alcohol, drug or substance intoxication, use, abuse, or addiction, whether directly or indirectly traceable to the insured being affected permanently or temporarily. Claims may be considered where registered drugs are administered and prescribed by a registered medical professional.
- Any psychiatric or psychological condition, emotional or nervous conditions including, but not limited to depression, insanity, psychosis, stress-related and affective disorders, unless specified as part of a benefit entitlement.
- Suicide, attempted suicide, or any intentional or deliberate self-injury and/or self-exposure to danger or risk except to save a human life.
- Medication (chronic or acute), drugs, prescriptions, consumables, and equipment used, unless they are part of the benefit entitlement.
- Devices, such as artificial joints, braces, crutches, dental implants, orthodontic, prosthodontic and all cosmetic dentistry including all forms of internal and external prostheses as defined, unless specified as part of the benefit entitlement of this policy.
- Cosmetic surgery where there is no clinical indication for treatment, including any treatment and costs resulting from these procedures, unless specified as part of the option benefit entitlement this includes but is not limited to gender re-assignment and gender re-assignment reversal procedures, any treatment, and admissions.
- Discounts negotiated directly with a service provider and the insured person and where reimbursement of a claim would benefit or enrich.
- Elective procedures that have no clinical or medical indication, including any treatment and costs resulting from these procedures, unless specified as part of the benefit entitlement.
- Investigations, treatment, or surgery for eating disorders, obesity, or weight management, including any consequence of such treatment.
- Investigations, treatment, medication, or surgery related to any condition where advice, diagnosis and/or treatment is received outside the borders of South Africa.
- BMI (Body Mass Index)
  a) The additional charge on claims by Registered Medical Professional for management of overweight and underweight patients for BMI. BMI codes **0018** and **0019** are not covered, unless specified as part of the benefit entitlement.
  b) Sirago will pay the additional charges by a Registered Medical Professional for the management of overweight and underweight patients for BMI claims, only if directly related to pregnancy and diseases that are non-lifestyle related.
- Investigations, treatment, or surgery related to infertility, artificial insemination, hormone treatment for infertility, or any other form of assisted reproduction.
- Any claim related to contraceptive device implantation, unless specified in option's benefit entitlement.
- Robotic surgery including specialised mechanical or computerised appliances and equipment, unless your Sirago option specifically makes provision for this type of cover.
- Any claim submitted where you and/or your dependant has previously been diagnosed with cancer in your lifetime will not qualify for the initial cancer diagnosis benefit.
- An event approved by the scheme outside of the normal scheme rules by Ex-Gratia will not be covered on this policy.
- An event resulting in or related to gender reassignment or gender reassignment reversal procedures, treatment or admission does not fall within the benefit entitlement.
- Add another bullet point with: Any costs related to emergency Prescribed Minimum Benefit (PMB) costs / medical interventions, unless defined as part of the benefits of this policy.

SPORT-RELATED EXCLUSIONS:

Any illness, injury or condition resulting from, or directly associated with professional sport as a paid profession, such as but not limited to:

a) Participation in any form of race or speed test, other than on foot.
b) Sports involving any mechanically propelled vehicles or crafts.
c) Participation in a sport that is defined as hazardous or dangerous, except for scholars taking part in school activities.

STANDARD SHORT-TERM POLICY EXCLUSIONS

Sirago will not pay for any illness, condition, disease or injury, or the consequences or treatment resulting from or associated with:

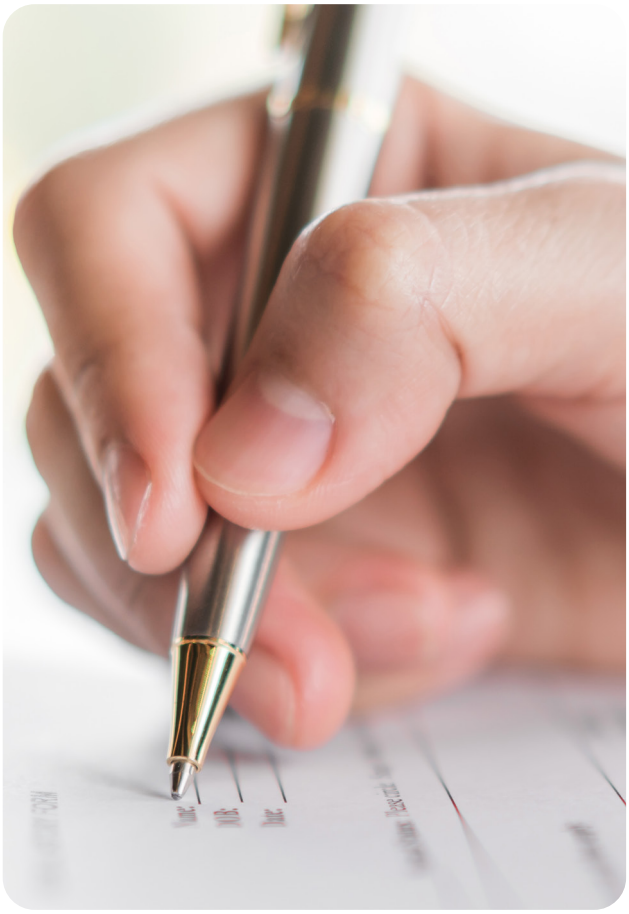
- Any claim arising directly or indirectly from active involvement in war, invasion, an act of a foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or political risk of any kind, or any act of any person acting on behalf of or in connection with any organisation, group or activity aimed at overthrowing any government by force or any deliberate act of terrorism or violence.
- Any riot, strike, or public disorder (including civil commotion, labour disturbances or lock-out) or any act or activity resulting in, or calculated to bring about a riot, strike, or such disorder.
- Active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike, or the activities of locked-out workers.
- The act of any lawfully established authority, police force, security force, or any other local, provincial, or national body, in controlling, preventing, suppressing or in any other way dealing with any event referred to in the clauses above.
- Compensation in terms of the War Damage Insurance Act 85 of 1976.
- Nuclear weapons or nuclear material, ionizing radiation, or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For this exception combustion shall include any self-sustaining process of nuclear fission.
- Any loss arising from any contractual liability.
- Any consequential loss or damage whatsoever.
- Any attempt by you to commit an unlawful act.

The above is a summary of the terms and conditions.
For a concise list, please refer to the Policy Wording which forms part of your Schedule of Insurance.

#DIDYOUKNOW

Gap cover is a non-life insurance product which complements your medical scheme benefits.
It is not the same as a medical scheme and cannot take the place of a medical scheme.
To qualify for Gap cover you need to have a policy with a registered medical scheme in South Africa.

HOW TO CLAIM



1. SIRAGO WEBSITE CLAIM SUBMISSION

Navigate to the Sirago website: **https://sirago.co.za** and select the “Submit a claim” button, which will take you to the claim form.

Follow the step-by-step guide on submitting the claim.
You will need the following information with you when you submit the claim:

- Your policy number, this will start with SIR / OMGC / SIRNG
- Policyholder’s details. This is the person who holds the policy with Sirago.
- All claim requirements for the claim submission.

2. EMAIL CLAIM SUBMISSION:

Submit all the claim documents required to **nedgroup@sirago.co.za**.

Remember to include the following information in the submission:

- Your policy number, this will start with SIRNG
- The claim form needs to be fully completed and signed by the policyholder of the Sirago policy.
- All claim requirements for the claim submission. (Refer to the required documents list below.)

SUBMIT YOUR DOCUMENTS

We must receive your claim with all supporting documentation within **180** days after the insured event.

DOCUMENTS REQUIRED WHEN CLAIMING

- Sirago Gap Cover claim form completed and signed by the Policyholder.
- Hospital and related accounts substantiating your claim.
- Medical scheme statement reflecting all the payments made by your medical scheme for the treatment date of the health event.
- Completed medical reports substantiating the clinical information or any other documentation if requested by our claims team.
- Pre-authorisation letter from your medical scheme for **co-payment** claims.
- **Value Added Benefit claims:** Documentation and certification which may include a death certificate or a report from a registered medical practitioner confirming total permanent disability.
- **Value Added Benefit claims:** A monthly confirmation of membership from the Medical scheme is required for **Medical Scheme Premium Waiver** benefit, this needs to include the month and the monthly premium.
- **Initial Cancer Diagnosis:** We require a histology report confirming the first diagnosis of cancer.

SCAN TO CLAIM

Sirago Whatsapp Line

SCAN ME

Sirago Website

IMPORTANT TO KNOW
Make sure to claim in the policyholder’s name (the policyholder is the main member).

+27 10 599 1163
for claims assistance

NEDBANK INSURANCE

+27 10 599 1163

nedgroup@sirago.co.za

sirago.co.za

ENTHUSIASM IS COMMON
RESILIENCE IS RARE **#FUTUREBUILT**

BROKER DETAILS

NEDBANK INSURANCE DISTRIBUTION, A DIVISION OF NEDBANK LIMITED

FSP: 9363

ADDRESS: Nedbank Insurance, Newtown Junction Campus, 100 Carr St, Newtown, 2001

EMAIL: nedgroup@sirago.co.za

SIRAGO U•M•A

GENRIC Insurance FSP: 43638