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Technical Guide 2024

INSURED BY
CENTRIQ
INSURANCE
A LICENSED NON-LIFE INSURER

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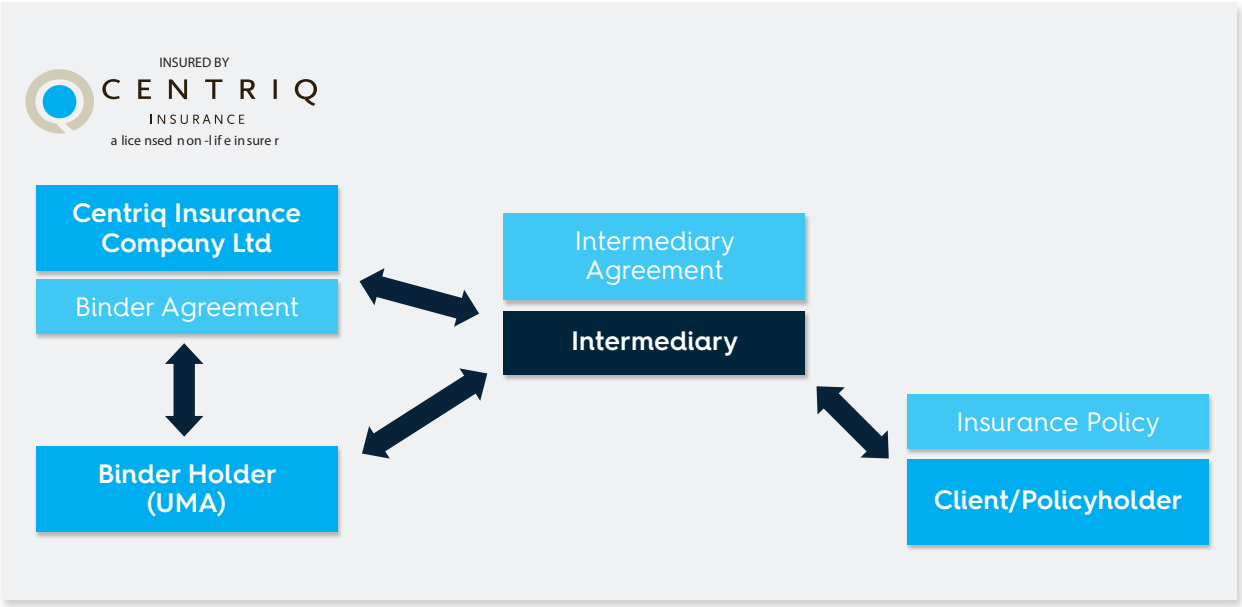
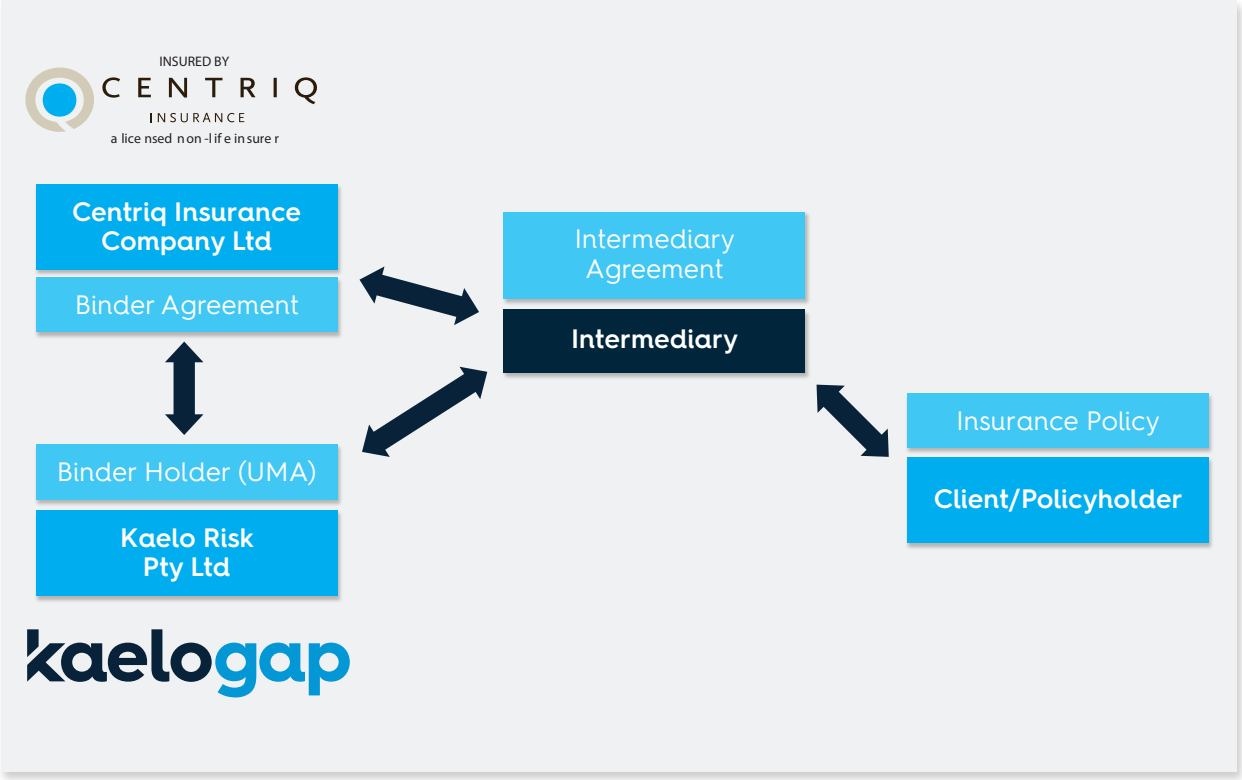
STRUCTURE & BACKGROUND

Below is an organogram of stakeholders in the Kaelo Risk Pty Ltd value chain:





Kaelo Risk Pty Ltd is registered with the Financial Sector Conduct Authority as an underwriting manager ('UMA') and we distribute our products exclusively via independent intermediaries.

We have invested in our staff and systems to ensure efficient and prompt service levels. All administrative functions are undertaken by Kaelo Risk Pty Ltd (i.e. premiums, claims, queries, etc.)

In terms of a binder agreement, governed by the Binder Regulations of the Short-Term Insurance Act, Centriq fully underwrites all our Kaelo Gap insurance products. Centriq Insurance Company Limited, FSP 3417, is a licensed non-life Insurer.

KAELO GAP OPTIMA & KAELO GAP CORE OVERVIEW & BENEFITS

Kaelo Risk Pty Ltd provides two solutions for the gap cover market: Kaelo Gap Optima and Kaelo Gap Core.

Kaelo Gap is specifically designed to provide an optimal gap cover solution regardless of the medical scheme or benefit option.

Core Benefits

The Core Benefits are benefits which are subject to the Overall Annual Limit as defined by the Demarcation regulations (R198 660 for 2024).

The following Benefits are defined as Core Benefits:

- Tariff Shortfalls
- Co-Payments and Deductibles
- Shortfalls from Sub-Limits
- Oncology Tariff Shortfalls
- Oncology Sub Limits
- Oncology Co-Payments
- Out-of-Hospital Tariff Shortfalls
- Oncology First-Time Diagnosis
- Penalty Co-Payment
- Innovative Oncology Medicines
- Dental Reconstruction Benefit

Prescribed Minimum Benefits (PMBs) procedures are covered under Core Benefits and are subject to clinical review by our specialist third party, Med ClaimAssist.

Med ClaimAssist partnered with Kaelo to assist us in ensuring that the Medical Scheme has processed the claim correctly and/or negotiate a discount with the providers. These savings achieved assist us in managing costs which impact year-on-year premium increases.

This process will not affect our standard turnaround time of 7 to 14 working days, however, MedClaim Assist will notify the Policyholders should there be any unforeseen delays.

Core Benefits

The Overall Annual Limit is R198 660 per Insured Party Per Annum. which is the maximum combined Benefit payable by the Insurer for all Core Benefit clauses. The Benefits apply only for services rendered within the territory of the Republic of South Africa. Any services provided outside of the borders of South Africa are excluded from cover.

Benefits	Description	Limit
Tariff Shortfalls	Benefits will be paid in respect of services occurring during a Hospital Episode that are rendered and charged for by a Medical Practitioner. This Benefit requires your Medical Scheme to pay their portion of the claim from your hospital/ risk benefit. **Core Benefits Tariff Shortfalls Example:** Mr S is on a Medical Scheme – plan A which covers him to a maximum of 100% of the Medical Scheme rate. This means that the Medical Scheme will pay all expenses towards Mr S' Treatment costs. The Medical Scheme rate for a total colonoscopy is R2 000 (100%) which means that the maximum that the Medical Scheme will pay is R2 000 (100%). The specialist performing the procedure charged R12 000 which is six times the Medical Scheme Tariff (600%). The maximum Benefit payable by this Policy for this procedure is therefore: • R12 000 – Fee charged by the specialist • LESS R2 000 – Benefit paid by Medical Scheme • = R10 000 – The gap cover Benefit.	The Benefit provided is for charges above the Medical Scheme Tariff limited to an additional six times (600%) that of the Medical Scheme Tariff, subject to the Overall Annual Limit.
Co-Payments and Deductibles	Benefits payable are for a standard Co-payment or an upfront Deductible amount for the cost of a Medical Procedure. The Benefit payable is equal to the fixed value Deductible or Co-payment amount, as defined in the rules of the Insured Party's Medical Scheme. This Benefit excludes any Deductible or Co-payment that is specified by the Insured Party's Medical Scheme as a percentage of costs and not a specified rand amount.	Subject to the Overall Annual Limit.
Shortfalls from Sub-Limits	This Benefit will apply for services provided during a Hospital Episode, where the charges relating to the service supplied are greater than the Sub-limit benefit paid by the Insured Party's Medical Scheme. The Benefit payable is equal to the charged amount, less the amount paid by the Insured Party's Medical Scheme, and subject to the Benefit limit.	Limit: R 64 500.
Oncology Tariff Shortfalls	Benefits will be paid in respect of oncology and related Treatment, that has been approved by the Insured Party's Medical Scheme, for treating cancer (malignant neoplasm) and which occurs during an Insured Event. This Benefit requires your Medical Scheme to pay their portion of the claim from your hospital/risk benefit **Oncology Tariff Shortfalls Example:** Mr T is on a Medical Scheme – plan B which covers him to a maximum of 100% of the Medical Scheme rate. This means that the Medical Scheme will pay all expenses at the defined Medical Scheme rate towards Mr T's Treatment costs. The Medical Scheme rate for the specific oncology Treatment is R20 000 (100%). This means that the maximum that the Medical Scheme will pay is R20 000. The total cost for the specific oncology Treatment required by Mr T is R100 000 which is five times the Medical Scheme Tariff (500%). The maximum Benefit payable for this procedure is therefore: • R100 000 – Oncology Treatment Cost • LESS R20 000 – Benefit paid by Medical Scheme • = R80 000 – Your gap cover Benefit.	The Benefit provided is for charges above the Medical Scheme Tariff, limited to an additional five times (500%) of the Medical Scheme Tariff, subject to the Overall Annual Limit

Benefits	Description	Limit
Oncology Sub Limits	Benefits will be paid in respect of oncology and related Treatment, that has been approved by the Insured Party's Medical Scheme, for treating cancer (malignant neoplasm) and which occurs during an Insured Event. Benefits will be paid in respect of services, where the charges relating to the services supplied, are greater than the benefit sub-limit that applies to oncology Treatment of the Insured Party's Medical Scheme plan type. The Benefit payable is equal to the charged amount, less the amount paid by the Insured Party's Medical Scheme.	Subject to the Overall Annual Limit.
Oncology Co-Payments	Benefits are payable in respect of oncology and related Treatment, that has been approved by the Insured Party's Medical Scheme, for treating cancer (malignant neoplasm) and which occurs during an Insured Event. The Benefit payable is equal to the Co-payment applied once related costs have exceeded the specific threshold defined by the Insured Party's Medical Scheme.	The maximum Benefit payable is limited to a 20% Co-Payment, subject to the Overall Annual Limit.
Out-of-Hospital Tariff Shortfalls	This Benefit provides additional cover of up to 500% of the Medical Scheme rate for outpatient procedures, subject to the costs being funded from the risk/hospital benefit by the Insured Party's Medical Scheme. **Out-of-Hospital Tariff Shortfalls Example:** Mr V is on a Medical Scheme – plan C which covers him to a maximum of 100% of the Medical Scheme rate. This means that the Medical Scheme will pay all expenses at the defined Medical Scheme rate towards Mr V's Treatment costs. Mr V has opted to undergo an arthroscopy of his shoulder out of Hospital. The Medical Scheme rate for a total arthroscopy is R2000 (100%). This means that the maximum that the Medical Scheme will pay is R2000 (100%). The specialist performing the procedure charged R10 000 which is five times the Medical Scheme Tariff (500%). The maximum Benefit payable for this procedure is therefore: • R10 000 – Fee charged by the specialist for the arthroscopy • LESS R2 000 – Benefit paid by Medical Scheme • =R8 000 – Your gap cover Benefit.	The Benefit provided is for charges above the Medical Scheme Tariff, limited to five times (500%) of the Medical Scheme Tariff, and subject to the Overall Annual Limit.
Penalty Co-Payment	Notwithstanding the exclusion relating to penalties, this Benefit will pay a fixed value Penalty Co-payment or Deductible, or a percentage penalty Co-payment up to a maximum of 30%, for the voluntary use by an Insured Party of a Hospital that is not part of a Hospital Network. Any other liability arising against an Insured Party from a Penalty, that is not a fixed value Penalty Co-payment defined in the rules of the Insured Party's Medical Scheme, remains an exclusion.	Subject to two events per Family Per Annum and a maximum of R18 550 per event and subject to the Overall Annual Limit.
Innovative Oncology Medicines	Benefits will be paid in respect of defined Innovative Oncology Medicines approved by the Insured Party's Medical Scheme.	The Benefit payable is equal to the total cost of the Innovative Oncology Medicine less the amount paid by the Medical Scheme from the Insured Party's hospital/risk benefit up to a maximum value equal to the lesser of 25% of the total cost or R13 780.

Benefits	Description	Limit
Dental Reconstruction Benefit	Benefits are only payable in respect of dental reconstruction surgery being required as a direct result of Accidental Injury or from oncology Treatment/s or Medical Procedure/s that occurred after the Insured Party›s Effective Date of cover. The Benefit payable is equal to the total cost of Treatment less the amount paid by the Medical Scheme from your hospital/risk benefit. The Benefit is only payable during an Insured Event. **Dental Reconstruction Example:** Mr X is involved in a motor vehicle accident which damaged his teeth. Mr X is required to have dental reconstruction as a result of this. Mr X was admitted to Hospital for his surgery. The total cost for Mr X's Treatment was R10 500. Mr. X's Medical Scheme paid R3 000 toward the dental surgeon's account from his hospital benefit. Kaelo Gap will calculate the Benefit payable to Mr X as: • R10 500 (Charged Amount) • Less R3 000 (Paid by Medical Scheme) • = R7 500	Subject to two events per Family Per Annum and a maximum amount of R49 900 Per Annum and subject to the Overall Annual Limit.

Benefit Extender

The Benefit Extender is automatically included within Kaelo Gap so does not require any benefit choice or an additional premium.

The Benefit Extender provides financial protection in circumstances where indirect medical costs are incurred as a result of the major medical events listed below:

Benefits	Description	Limit
Family Booster	A lump sum Benefit is payable when a Premature Birth occurs.	The lump sum Benefit is R15 900.
Casualty Child Illness	Benefits will only be paid in respect of emergency outpatient services that are provided within a casualty ward of a Hospital. The Benefit is only payable in the event of after-hours treatment in an Emergency situation. After-hours are Mondays to Fridays between 18:00 and 08:00 and all-day Saturdays, Sundays and South African public holidays. The Benefit payable is equal to the total cost of Treatment less the amount paid by your Medical Scheme from your hospital/risk benefit. If payment is made from your available Medical Savings Account, or from your own pocket, we will refund that too.	Subject to two events Per Annum and a maximum of R2 860 per event. The Benefit only applies to children under age 12.
Accidental Casualty	Benefits will be paid in respect of emergency outpatient services that are a direct result of Accidental Injury and are provided within a casualty ward of a Hospital. The Benefit payable is equal to the total cost of Treatment less the amount paid by your Medical Scheme from your hospital/risk benefit. If payment is made from your available Medical Savings Account, or from your own pocket, we will refund that too. No Benefit is payable for services that are related to an Illness or that are not delivered within a casualty ward of a Hospital.	Subject to a maximum of R18 450 per event.

Benefits	Description	Limit
Hospital Booster	The following daily lump sum Benefit is payable where an Insured Party is admitted to a Hospital, and such an Insured Event occurred as a direct result of either Accidental Injury or Premature Birth. For the purposes of the Benefit calculation, the first day is defined as beginning at the time of admission to Hospital and ending 24 hours later. All subsequent days are defined as beginning and ending on the same start and end times as the first day. The following Benefit limitations apply: If more than one Insured Party in the Family is hospitalised as a result of the same event, only the Insured Party with the longest Hospital Episode will receive a Benefit. No Benefit is payable after day 30 of any Hospital Episode.	A maximum of two Hospital Episodes per Family are covered under this Benefit Per Annum, limited to R29 300 per Insured Party Per Annum. The Benefit is payable from day one of the Hospital Episode: • R480 per day from the 1st to the 13th day (inclusive). • R860 per day from the 14th to the 20th day (inclusive). • R1 700 per day from the 21st to the 30th day (inclusive).
Family Protector	The lump sum Benefit is payable upon the death or Permanent Disability of an Insured Party due to Accidental Injury.	Limited as follows: • Children below six years: R20 000. • All other Insured Parties: R30 000.
Oncology First-Time Diagnosis	A lump sum Benefit for first-time diagnosis of cancer to the medical equivalent of stage 2 or higher form of cancer. The Benefit is only payable during an Insured Event. The Benefit is subject to one claim per Insured Party for the lifetime of the Policy. It excludes any form of cancer that was previously identified or required Treatment. It excludes cancer diagnosed prior to 2024	Limit: R15 000
Medical Scheme Contribution Waiver	A lump sum Benefit is payable upon the death or Permanent Disability of the Policyholder due to Accidental Injury and where the Policyholder is the principal member of the Medical Scheme. In the event of death, this Benefit will only apply (become payable) where there are dependants registered on the Medical Scheme, who are being paid for by the Policyholder. The Benefit payable is equal to the monthly Medical Scheme contribution applicable after the qualifying event above, multiplied by six and subject to an overall maximum limit. This Benefit is limited to one event over the Policy lifetime.	The Benefit payable is subject to an overall limit of R35 500
Gap Premium Waiver	In the event of the death or Permanent Disability of the Policyholder as a result of an accident, Policy Premiums will be waived. In the event of death, the Benefit will only apply (become payable) where the Policyholder is the principal member of the Medical Scheme and only if there are dependants registered on the Gap policy who are being paid for by the Policyholder.	Waived for a period of six months from the date of the of event. This Benefit is limited to one event over the Policy lifetime.

Benefits	Description	Limit
Road Accident Fund Claims	An end-to-end legal service is provided by the nominated Service Provider of Kaelo to assist Insured Parties with legitimate claims against the Road Accident Fund. Service Providers are contracted to Kaelo and not to the Insurer: Centriq Insurance Company Limited.	Included.

To help you understand the benefit criteria, additional guidelines are provided below:

Benefit	Kaelo Gap Criteria
Co-payments	Defined/Fixed Rand value only. Defined by Medical Scheme.
Penalty Co-payment	Two events per family per annum. We cover penalty Co-payments or Deductibles, up to 30%, for the voluntary use by an Insured Party of a non-Network Hospital.
Sub-Limits	Only covered during a Hospital admission.
Out of Hospital Tariff Shortfalls	Defined list in the Policy document. Only these will be covered and there must be a difference between what is charged by a healthcare practitioner versus what is paid by the Medical Scheme tariff.
Accidental Casualty	Must be in the casualty ward of a hospital; Must be due to an accident. "Accidental Injury": bodily injury caused by violent, unintentional, external and physical means). All expenses incurred whilst in the casualty ward would be covered under this benefit in a single event. For example: Crutches; Moon boots; Medications; Slings.
Innovative Oncology Medicines	This only applies to our defined list of innovative medicines where approval has been attained from the Medical Scheme and only to treat cancer.
Dental Reconstruction	Payable only due to an accident or due to Oncology treatment. This must have happened after the inception of the Policy. If there are multiple admission dates linked to one event we will cover these as one event up to the maximum allowed rand value of R49 900. We pay the difference between what is charged by a healthcare practitioner versus what is paid by the Medical Aid tariff. Must have been paid by the Medical Scheme from the risk portion and treatment must have occurred during an insured event.
Family Booster	Applies to premature birth. Premature birth must have been 41 days or more before the expected due date. A doctor's letter is required for confirmation.
Hospital Booster	Only applicable in an accident or due to premature birth (41 days or more before the expected due date). Only pays up to a maximum of 30 days. If two people from the same family are admitted, the longest stay attracts the benefit.

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TERMS & CONDITIONS

- There Is no maximum entry age, however, an over-60 premium will be applied to individuals over the age of 60.
- Waiting periods may apply - this will be indicated on the Policyholder's Policy Schedule.
- Cover only applies to the Policyholder, spouse and children (up to 25). Special dependants may be accepted but must be applied for and can only enjoy cover if they have been explicitly accepted by Kaelo. Proof of family relationship and financial dependency must be provided on an application for special dependants to kaelogap@kaelo.co.za
- Families that are covered by two medical schemes can be covered together under one Kaelo Gap Policy. Adequate proof of the family relationship will be required when submitting a claim.
- A spouse dependent on the Medical Scheme can be the principal Policyholder on the Kaelo Gap Policy.
- The option of a single and family Premium is available to private individuals. This Premium must be selected on the application form. The onus is on the Policyholder to ensure Kaelo Gap is kept up to date on any changes to their Single/Family status. No claims for dependants will be paid on a Single Policy.
- Policyholders who leave their employer group and wish to continue in a private capacity may do so. A Continuation form must be completed. The individual Premium will apply once the continuation has been done and Premiums will be collected via debit order.
- The Policy can be cancelled at any time, by giving 31 days, prior written notice. We may cancel this cover at any time, by giving you 31 days, prior written notice.

WAITING PERIODS & UNDERWRITING

The following waiting periods and underwriting procedures are applicable to new; existing groups and individuals.

Waiting Periods

- Three months General Waiting Period on all benefits – This excludes claims as a result of an Accident.
- 12 months Condition-Specific waiting period on pre-existing conditions.
- The Policy can be cancelled at any time, by giving 31 days, prior written notice. We may cancel this cover at any time, by giving you 31 days, prior written notice.

A Condition-Specific Waiting Period will apply, if within the first 12 months a claim is received, a pre-existing questionnaire will be requested. This questionnaire is completed by the diagnosing provider.

Some or all of these may be waived or adjusted.

If the applicant has an existing gap cover of similar benefits, Kaelo Gap will review the waiting periods

Compulsory Groups

If groups of 20 or more join Kaelo Gap, waiting periods will be waived. Future employees of this group will also have their waiting periods waived.

It is a requirement that all eligible employees join Kaelo Gap as a condition of their employment.

The compulsory criteria must be confirmed on the Kaelo Gap Employer Application form.

Voluntary Groups with other gap providers

If prospective groups of 20 or more move their cover from another gap provider to Kaelo Gap, the waiting periods for the transferring Policyholders will be waived. All existing gap cover Policyholders are required to join Kaelo Gap unless otherwise agreed upon in writing.

This waiver does not apply to future employees of such groups, i.e. after the initial group has transferred to Kaelo Gap full waiting periods will apply to new Policies.

For any voluntary group where new Policyholders join the group under the following conditions:

- During a window period provided by Kaelo Gap to that group. The three-month General waiting period will be waived, however, the 12-month Condition-Specific waiting period will apply.

EXCLUSIONS

A full list of the exclusions is contained within the Kaelo Gap policy documents. The pertinent areas that are worth noting here are:

The Insurer shall not be liable for any claim caused by or related to, whether such cause or related cause is as a direct or indirect consequence of any of the following:

- Any Treatment or Medical Procedure related to obesity.
- All costs related to ward fees, theatre fees and other Hospital expenses including materials and medication on the Hospital account
- Cosmetic surgery except in the case where reconstructive cosmetic surgery is necessitated, in the sole opinion of the Insurer, as a direct result of Trauma or other essential non-elective Treatment or Medical Procedure.
- Any procedure or examination where there is no objective indication of impairment in normal health.
- The consumption of any drug or narcotic, whether legal or illegal, unless legally prescribed by and taken in accordance with the instructions of a Medical Practitioner.
- Any incident, Illness, Accidental Injury, or event directly or indirectly caused by the continuous and excessive consumption of alcohol or where the Insured Party suffers from alcoholism.
- Any incident, Illness, Accidental Injury or event directly or indirectly attributable to the Insured Party having a blood alcohol content exceeding thirty milligrams per one hundred millilitres of blood.
- Participation or attempted participation by any Insured Party in any of the following:
  - Defence force, police force, medical rescue service, firefighting service, correctional services facility or the disarming of explosives;
  - Aviation activities where any medical expense incurred in relation to such activities are insured by any other party (excludes fare-paying passengers in a licensed passenger carrying aircraft);
  - Hazardous Sport as defined, regardless of whether activities are performed privately, socially, during practice sessions, while participating in organised events, as an amateur or a professional;
- Any claim that is excluded or rejected by the Insured Party's Medical Scheme.
- Any claim that does not form part of the registered benefits of the Insured Party's Medical Scheme but has been paid on an ex-gratia basis.
- The following procedures, items, services, Service Providers or events:
  - External prosthesis;
  - Any appliances including, but not limited to, wheelchairs, beds or convalescing equipment;

- All specialised dental procedures including, but not limited to, crowns, bridges, dental implant related procedures, orthognathic surgery, temporo-mandibular joint ("TMJ") surgery, labial frenectomy, bone augmentations, bone or tissue regeneration. The above definition does not include Basic Dentistry, as defined in this Policy. This exclusion is not applicable to the Dental Reconstruction Benefit in this Policy.
- Harvesting and/or preserving of human tissues, including but not limited to stem cell regeneration;
- Breast enlargement;
- Gastroplasty, lipectomy or otoplasty;
- Gender reversal procedures;
- Therapeutic massage therapists;
- Institutions that primarily cares for persons who are mentally handicapped, blind, deaf, mute or in any other way physically handicapped;
- Convalescent homes or homes for the elderly;
- Places of rest or recouperation;
- Rehabilitation (drug addiction, alcoholism, eating disorders or any other form of addictive behaviour), frail care or hospice services;
- Health hydro or alternative therapy clinics;
- Step-Down facilities;
- TTO (To-Take-Out) medicines.

- Any fee charged by a Medical Practitioner, Hospital or other medical service provider that constitutes Split Billing in this Policy. This exclusion does not apply to Balance Billing in this Policy.
- Any Treatment or Medical Procedure for infertility.
- Any Treatment or Medical Procedure that, in the sole opinion of the Insurer is of such a nature that it is not considered to be medically necessary, or where alternative conservative Treatment would provide a similar outcome or is of such a nature that there is no likely improvement in the medical condition of the Insured Party.
- Any additional costs incurred as a result of confinement in a private Hospital ward (except where medically necessary).
- Claims older than six months.

PREMIUMS – 2024

Premiums are established as follows for groups and individuals.

Premiums for Groups of 20 or more

Kaelo Gap risk rates each prospective client group in accordance with demographic composition and medical scheme benefit option mix. It is, therefore, a requirement to obtain a quote for each prospective corporate client in order to determine the premium for the group.

Member data will be required for this purpose. This includes:

- ID Number or date of birth and gender
- Medical Scheme benefit option

The Premiums for future Policyholders of existing groups will be the same as the group's Premium.

Each employer group's premiums are revised annually based upon the claims experience of the group and the expected medical inflation for the coming year.

Premiums for Individuals and Groups less than 20

Rate Table				
	Single Under 60	Family Under 60	Single Over 60	Family Over 60
Kaelo Gap Optima Including Lifestyle Benefits	R380	R542	R689	R983
Kaelo Gap Optima Excluding Lifestyle Benefits	R362	R524	R671	R965
Kaelo Gap Core Including Lifestyle Benefits	R266	R379	R482	R688
Kaelo Gap Core Excluding Lifestyle Benefits	R248	R361	R464	R670

Policyholders continuing with cover in their private capacity after resigning from an employer group automatically default to the standard individual rate applicable. Only the balance of waiting periods will apply in such instances and a new policy number and schedule is issued.

If the Policyholder has a Post Retirement Promise in place with their employer they can continue to pay the employer group premium as a pensioner. This branch set-up must be arranged with the Sales or CRM from Kaelo Gap.

APPLICATION PROCEDURE

A Corporate Application form must be completed for Policyholders of employer groups.

**Note that premium collections for groups can be done in one of the following 3 ways:

i. EFT Payment by the employer (i.e. payroll deductions by the employer)
ii. Group Debit Order
iii. Individual debit order deductions against each Policyholder's personal bank account.

Kaelo Gap requires each applicant to complete an Individual Application form (online or PDF) and submit IT to their broker who will submit it to Kaelo Gap.

Once Kaelo Gap receives the Individual Application forms, Policyholders will be loaded on the system and policy documents will be sent via email to each Policyholder. An SMS is also issued to the Policyholder notifying them of the email. This will be sent within the legislative guideline of 31 days.

BILLING PROCESS

Billing statements are issued to all groups on the 1st of each month. This is a Pro-forma billing. This allows the employer group to respond to Kaelo with any specific changes to note for the month in question. Final billing is issued on the 20th of each month. Premiums are due by the last day of each month.

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CLAIM PROCESS

A Claims Journey document is available at https://www.kaelo.co.za/wp-content/uploads/2021/10/Journey-of-a-Kaelo-Claim.pdf which illustrates the claims process and what Policyholders can expect.

A Claim form can be downloaded or an online form can be completed on the Kaelo website -

www.kaelo.co.za https://www.kaelo.co.za/quick-links/

The Claim form includes a checklist per claimed benefit for claimants to determine what is needed for their claim to be processed as quickly as possible.

The following minimum supporting documents are required with the Claim form

1. Claims Transaction History from the Medical Scheme;
2. Relevant Doctor's Accounts;
3. Hospital Account (first 1-4 pages showing admission/ discharge times and ICD codes).

Claim payments are made on a daily basis.

An email and SMS notification are issued to the Policyholder when:

- The claim is first captured;
- Requesting outstanding documentation, if required
- Authorising the claim payment.

NB: "Signing of the Claim form disclaimer allows us to pay the healthcare provider directly if a discount is negotiated".

CONTACT DETAILS

All submissions: Claims; Applications; Billing; Queries: Kaelogap@kaelo.co.za

Call Centre: 0861 493 587

Complaints: escalations@kaelo.co.za

Anticipated turnaround times:

Anticipated turnaround times	
Escalations	Acknowledgement - 1 Business day
Applications	1 - 2 Business days
Billing	1 - 2 Business days
Claims	7 - 14 Business days from receipt of all required documents
Claims Queries	1 - 2 Business days