GENERAL CLAIM FORM

Please complete this form in block capitals using black ink

GLOBAL HEALTH®
Health Insurance for Expatriates

PLEASE NOTE: Claims for dental treatment, maternity treatment, the well-being benefit, and compassionate home travel, must be made on their own claim forms which are available at www.william-russell.com/uae/policy-holder/make-a-claim or by calling +971 4 2697708.

IMPORTANT – PLEASE READ THESE INSTRUCTIONS CAREFULLY: SECTION A MUST BE COMPLETED BY THE CLAIMANT, OR BY THE CLAIMANT'S GUARDIAN OR LEGAL REPRESENTATIVE. SECTION B MUST BE COMPLETED BY THE TREATING DOCTOR. WE CANNOT SETTLE YOUR CLAIM UNLESS SECTION B IS FULLY COMPLETED BY THE DOCTOR. ALL CLAIMS MUST BE SUBMITTED WITHIN 6 MONTHS OF THE DATE OF THE FIRST CONSULTATION.

SECTION A: TO BE COMPLETED BY THE CLAIMANT OR THE CLAIMANT'S GUARDIAN OR LEGAL REPRESENTATIVE

Full name of Global Health policyholder: **Title: Mr/Mrs/Miss/Ms/Dr**

Full name of claimant (If not the policyholder)**:** **Date of birth** (DD/MM/YYYY)**:**

Global Health plan policy number: **Sex: ❑ Male ❑ Female**

Full mailing address:

Telephone: **Fax:**

Email (Failure to provide your email address may result in a delay in processing your claim)**:**

Please state the name and address of your regular doctor or clinic:

Name:

Address:

Telephone: Fax:

Email:

2. DETAILS OF THE CONDITION BEING TREATED

Please describe your symptoms:

When were you first aware of your symptoms?

When did you first consult a doctor with regard to these symptoms?

What is your doctor's diagnosis?

Have you ever suffered from this or any related condition before? ❑ YES ❑ NO If YES, when did you suffer from this or the related condition?

Is your claim related to injuries sustained in an accident? ❑ YES ❑ NO If YES, please provide details of the accident and injuries sustained:

3. PLEASE LIST THE BILLS FOR WHICH YOU ARE SEEKING REIMBURSEMENT

Please attach the fully itemised accounts including copies of the credit card terminal receipts if you have paid by card. If the total value of your claim is over $500, you must submit the originals to us by post.

Date(s) of treatment:	Details of the bills you have enclosed for reimbursement:	Please state currency and amount paid:

4. PLEASE STATE HOW YOU WISH TO BE REIMBURSED

❑ **PAYMENT TO YOUR VISA CARD** NB: We can only make payment to a visa card, and settlement can be provided in Sterling, Dollars or Euros. If your previous claim reimbursement was made to a credit card, you will need to recomplete the details below as, for security purposes, credit card information is not stored.

Card number:

Name on card: Expiry date (DD/MM/YYYY):

Address to which card is registered (If different from part 1):

❑ **PAYMENT TO YOUR BANK ACCOUNT**

Currency in which you would like to be reimbursed:

If you have previously submitted a claim, are your payment details the same? ❑ **YES** ❑ **NO** ❑ **NOT APPLICABLE**

If YES, please confirm the last 4 digits of your account number: and then go to part 5.

If no, please provide your account details below:

Bank name and address:

Account holder name(s):

IBAN number*: Sort code:

BIC Number*:

* BIC and IBAN details are necessary for all transfers to European and UAE bank accounts. BIC and bank account number are necessary for all transfers to international bank accounts.

5. DECLARATION AND AUTHORISATION

Do you have any other insurance cover?

❑ No, I have no other health insurance cover ❑ Yes, I have other health insurance cover with: _____

I hereby give William Russell Dubai Team (part of Dubai Insuance Company psc) authorisation to correspond with me by email regarding my claim. I understand that these emails may contain reference to my medical condition/s and financial payment information. I also authorise any doctor of medicine, hospital or other health professional who has attended or examined me, to furnish William Russell Dubai Team and/or to its authorised representative any and all information with respect to illness, medical histoty, consultation, prescription, medical investigations or treatment and copies of all hospital records and/ or medical records.

Name of patient:

Date of birth (DD/MM/YYYY):

Claim reference:

Signature of patient: **Date:**

SECTION B: TO BE COMPLETED BY THE CLAIMANT'S DOCTOR

1. PATIENT DETAILS

Patient's full name: **Sex: ❑ Male ❑ Female**

Date of birth (DD/MM/YYYY)**:**

Was the patient referred to you? ❑ YES ❑ NO If YES, please state the name and contact details of the referring doctor:

2. DATES

Please confirm the date the patient first registered at your facility (DD/MM/YYYY)**:**

On which date did the patient first consult you for this particular condition (DD/MM/YYYY)**?**

Please give a short description of your client's symptoms or injuries, if they have suffered an accident:

In your professional opinion, on what date would the patient have been aware of their symptoms? (DD/MM/YYYY)

3. YOUR DIAGNOSIS

What is your clinical diagnosis?

4. YOUR TREATMENT PLAN

Please provide a treatment plan including details of test performed and medications currently being prescribed to the patient:

5. MEDICAL HISTORY

Please answer each of the following questions:

A. Has your patient previously suffered from this or from any related condition? ❑ YES ❑ NO

If YES, please give full details of the previous condition/related condition, and the dates on which it first occurred:

B. Does your patient have a history of any of the following:	**YES**	**NO**	**Details and date of onset:**
High blood pressure, high cholesterol, heart or circulatory disorders?	❑	❑	
Diabetes?	❑	❑	
Asthma, respiratory or allergic conditions?	❑	❑	
Spine, bone, joint or muscle conditions?	❑	❑	
Cancer?	❑	❑	
Psychiatric, psychological or mental disorders?	❑	❑	
Any other disease or injury requiring in-patient treatment?	❑	❑	

6. DECLARATION BY DOCTOR

I declare that I am the patient's treating doctor, and that the particulars given above are, to the best of my knowledge, full, true and complete.

Signature: **Date** (DD/MM/YYYY)**:**

Print your name and address:

Telephone: **Fax:**

Email:

Qualifications:

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP:

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DUBAI INSURANCE

William Russell Dubai Team
Dubai Insurance Company psc
PO Box 3027, Dubai, UAE.
T + 971 4 2697706 **F** + 971 4 2691304
claims.dubai@william-russell.com
www.william-russell.com/uae

WilliamRussell
Expatriate Insurance Specialists