

#### **CLAIM FORM**

#### **Important Notes**

- To assist us in processing your claim efficiently and speedily, please complete this form fully, clearly and legibly.
- Please complete Sections A, B, C, D and E.
- The attending doctor should complete Section B.
- All claims should be submitted within 6 months from the starting date of the treatment.
- Please attach all original bills, retaining photocopies for your personal reference.
- A separate claim form should be used for each patient and each medical condition.
- Processing of your claim may be delayed if the information provided is incomplete.

## SECTION A PATIENT DETAILS

Title	Mr. / Mrs. / Ms.
Name & Surname:	
Policy Number:	
Date of Birth:	d d m m y y
Adresss:	
Postcode: (if applicable)	
Country:	
Telephone:	
E-mail:	





# SECTION B MEDICAL DETAILS

all section must be completed by the doctor in overall charge of the patient's treatment

Medical Practition	ıer's d	etails:													
Name:															
Adress:															
Qualifications:															
Diagnosis:															
Onset date when symp	toms fir	s noticed	l by pat	ient:											
When did the patient fi	rst see a	doctor?													
Details of treatment:															
Details of operation:										(					
										4	3)				
Details of medication:	Ā														
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Hospital dates:	Ad	mission (	date:						Disc	harg	e da	te:			T
Name and address of a	dmiting	hospital	:		R	efere	nce n	umb	er: [			L			
Name:							$\overline{}$								
						4									
Adress:															
Telephone:															
Fax:															
Email:															





### SECTION C CASH BENEFIT

Cash Benefit. I confirm thatwas in hospital from						itai o	veiiii	giit v	· · · · · ·	at Ci	iaige	•	, ,	і ріаі	1 IIICI	udes a
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to					:	The	hosp	ital n	eeas	(0 3					n here	
and this hospital did not ch	arge for a	ccommo	dation													
C																
Section D																
PAYMENT DETAIL	LS															
Who would you like us to	pay? (ple	ase tick	one only	/) Doc	tor / ho	spita	С	)	M	ain m	nemb	er (	)		Pati	ent (
Payment by Electronic Fur	nds Trans	fer to a l	oank ac	count												
Bank name:																
SWIFT / BIC code *:																
Sort code (UK only):		-	-													
Account number / IBAN:																
Account name / payee:									1							
Currency for the transfer:									V							
Bank address:																
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Post / Zip code:																
Country:																

