



# CLAIM FORM

The insured member is required to complete the following claim form and attach all the original medical bills and supporting documentation when filing the claim. A separate claim form must be completed for each medical condition, each currency and each member. All sections must be completed.

## SECTION A: PATIENT DETAILS TO BE COMPLETED BY INSURED MEMBER

Name of Main Applicant \_\_\_\_\_ Membership No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Name of Patient (If other than the main Applicant) \_\_\_\_\_ Membership No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Present Contact Address \_\_\_\_\_  
\_\_\_\_\_

Telephone number \_\_\_\_\_ Email Address for Remittance Advice \_\_\_\_\_

## SECTION B: SETTLEMENT DETAILS

Provided your claim is eligible, settlement can be made by cheque in the currency of your plan or by bank transfer (EFT). Please note that bank charges will apply for bank transfers.

Total amount claimed (including currency): \_\_\_\_\_

Bank Transfer  Cheque

**Bank Transfer** – Please provide bank details:

Name of Account Holder: \_\_\_\_\_ Name of Beneficiary Bank & Branch: \_\_\_\_\_

Beneficiary Bank Account No: \_\_\_\_\_ Address of Bank & Branch: \_\_\_\_\_

SWIFT Address / Clearing Code (if applicable): \_\_\_\_\_

IBAN number (if appropriate): \_\_\_\_\_

NOTE: Payment shall not include clinic, physician and any other medical providers.

## DECLARATION & AUTHORISATION

(This part must be signed by the patient or patient's parent/legal guardian if the patient is below 18 years of age)

I hereby authorise any hospital, physician, person or organisation to disclose all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I certify that the above statements and answers are true and complete to the best of my knowledge and belief.

Signature of Main Applicant \_\_\_\_\_ Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_



**SECTION C: TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON**

Note: If there are multiple doctors, this section is to be completed by the last attending physician.

Patient's Name: \_\_\_\_\_

Membership number: \_\_\_\_\_

1. Diagnosis (BLOCK CAPITALS PLEASE)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What was the date of the first consultation? \_\_\_\_\_

3. Please specify onset date of symptoms: \_\_\_\_\_

4. Date Treatment received: \_\_\_\_\_

5. Nature of Treatment:

\_\_\_\_\_  
\_\_\_\_\_

6. Doctors previously consulted by the patient for the above condition:

Name	Approximate Date	Name of Clinic	Address
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name of Physician/Surgeon and Qualifications: \_\_\_\_\_

\_\_\_\_\_

Contact No.: \_\_\_\_\_

Signature of Physician/Surgeon: \_\_\_\_\_

Date: \_\_\_\_\_