PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS USING BLACK INK

GlobalHealth

GENERAL CLAIM FORM

WILLIAM RUSSELL
Peace of mind wherever you are

PLEASE NOTE: Claims for dental and maternity treatment must be made on their own claim forms which are available at www.william-russell.com or by calling +44 1276 486455.

IMPORTANT – PLEASE READ THESE INSTRUCTIONS CAREFULLY.

SECTION A OF THIS FORM MUST BE COMPLETED BY THE PATIENT OR THE PATIENT'S GUARDIAN OR LEGAL REPRESENTATIVE. IT IS IMPORTANT THAT YOU GIVE A CLEAR ANSWER TO EACH QUESTION.

IN SECTION B PLEASE LIST THE ACCOUNTS FOR WHICH YOU ARE CLAIMING REIMBURSEMENT AND ATTACH THESE ORIGINAL BILLS.

PLEASE NOTE THAT WILLIAM RUSSELL LTD WILL RETAIN ALL ORIGINAL BILLS AND THAT PHOTOCOPIES OF BILLS ARE NOT ACCEPTABLE. WE CANNOT REIMBURSE A PHOTOCOPIED BILL.

ALL CLAIMS MUST BE SUBMITTED WITHIN 6 MONTHS OF THE FIRST CONSULTATION. FAILURE TO SUBMIT YOUR CLAIM WITHIN THIS 6-MONTH PERIOD WILL INVALIDATE YOUR CLAIM.

SECTION C MUST BE COMPLETED BY THE TREATING DOCTOR.

PLEASE ENSURE THAT THE DOCTOR GIVES COMPLETE ANSWERS TO ALL THE RELEVANT QUESTIONS. PLEASE ALSO ENSURE THAT WE HAVE THE DOCTOR'S ADDRESS AND CONTACT NUMBERS. UNFORTUNATELY WE CANNOT SETTLE YOUR CLAIM UNLESS SECTION C IS FULLY COMPLETED BY THE TREATING DOCTOR. PLEASE NOTE THAT ANY CHARGES MADE FOR COMPLETING THIS FORM CANNOT BE REIMBURSED UNDER THE TERMS OF YOUR SCHEME.

SECTION A – YOUR CLAIM (To be completed by the patient or the patient's guardian or legal representative)

1. YOUR PERSONAL DETAILS

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

Full name of patient (if not the policyholder): **Date of birth:**

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

Full mailing address:

Telephone: **Fax:**

Email:

Please state the name and address of your personal physician (General Practitioner):

Name:

Address:

Telephone: **Fax:**

Email:

2. DETAILS OF THE CONDITION BEING TREATED

What are your signs and symptoms?

What is your diagnosis?

Have you suffered with these symptoms before? ❑ YES ❑ NO

If yes please provide dates of previous episodes:

When did you first notice symptoms of this current episode?

When was the first time you ever consulted your personal physician (General Practitioner) regarding these symptoms or any similar related symptoms?

When did you consult your personal physician regarding this episode of symptoms?

Have you ever claimed for this condition before? ❑ YES ❑ NO

If yes, please provide details of when and what treatment was covered:

In addition to the previous question, what treatment (whether privately or through any state system) have you previously received for these symptoms?

Did the condition arise as the result of an accident? ❑ YES ❑ NO

If yes, a) how did the accident occur?

b) If another party was involved, please provide full names and addresses:

3. COMPLETE THIS SECTION IF YOUR CLAIM IS FOR A HOSPITAL CASH BENEFIT

IMPORTANT

PLEASE NOTE THAT A HOSPITAL CASH BENEFIT IS ONLY PAYABLE IF YOU RECEIVED YOUR TREATMENT AND HOSPITAL ACCOMMODATION FREE OF ALL CHARGES AND PROVIDED THE TREATMENT IS COVERED BY YOUR PLAN. YOU MUST THEREFORE GIVE FULL DETAILS OF YOUR ILLNESS OR ACCIDENT IN SECTION 2 ABOVE.

Please confirm your admission date: **Your discharge date:**

PLEASE ENCLOSE A CERTIFICATE OF ADMISSION AND DISCHARGE FROM HOSPITAL.

SECTION B – REIMBURSEMENT

1. PLEASE ATTACH THE ORIGINAL, FULLY ITEMISED ACCOUNTS – PHOTOCOPIES ARE NOT ACCEPTABLE

Please list the bills for which reimbursement is being claimed:

PLEASE ENSURE THESE BILLS ARE ENCLOSED

Please state the currency and the amount(s) paid:

2. PLEASE STATE HOW YOU WISH TO BE REIMBURSED

Our preferred method of settlement is direct to your credit card or bank account. Please provide your details here to enable payment to be made:

❑ PAYMENT TO YOUR CREDIT CARD

Payment can only be made to Visa credit cards, and can only be made in the currency in which the policy premiums are paid.

Card number: Expiry date:

Name on card:

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

❑ PAYMENT TO YOUR BANK ACCOUNT

Account holder(s) name(s):

Currency in which you would like to be reimbursed:

UK bank in Sterling: ❑

Account Number:

Sort Code (UK Banks only):

(or) UK bank payments made in another currency: ❑

Account Number:

BIC number/SWIFT code:

(or) any other european bank: ❑

BIC Number:

IBAN number:

(or) another international bank ❑

BIC number if known:

Bank Name:

Account Number:

Bank Address (if BIC is not provided):

PLEASE NOTE IF THESE DETAILS ARE NOT PROVIDED PAYMENT WILL BE SETTLED BY DRAFT

3. DECLARATION AND AUTHORISATION BY THE PATIENT OR HIS/HER LEGAL REPRESENTATIVE

Do you have any other health insurance cover?

❑ I have no other health insurance cover ❑ I have another health insurance policy through:

PLEASE ENCLOSE DETAILS OF YOUR OTHER HEALTH INSURANCE POLICY

Under the terms of my health care scheme I acknowledge that William Russell Ltd may need to approach a medical practitioner with whom I have consulted in order to validate any claim. My signature below confirms that I authorise them to do this. My signature also confirms that I recognise that any charges made to obtain such information are my responsibility and not the responsibility of William Russell Ltd.

Furthermore my signature consents the release of my personal data (including health and medical records) in relation to my condition and any other information that may influence any future treatment thereof. This consent extends to the clinician who will treat my condition, my general practitioner, my hospital specialist, employer and/or appropriately selected third parties.

Signature of patient:

Relationship to patient (if not the patient): **Date:**

SECTION C – DOCTOR'S REPORT

This section must be completed by your treating doctor

1. PATIENT DETAILS

Please state the patient's full name:

Sex: ❑ Male ❑ Female **Date of birth:**

For how long have you known the patient? **Was the patient referred to you? ❑ YES ❑ NO**

If YES, please state the name and address and contact details of the referring doctor:

Name:

Address:

Telephone: **Email:**

2. DATES

a) On which date did the patient first contact you for this particular condition?

b) In your professional opinion, for how long before this date would the patient have been aware of these symptoms?

3. YOUR DIAGNOSIS

a) Please give a description of your client's presenting symptoms, (or injuries if your client has suffered an accident)

b) What is your clinical diagnosis?

c) How was this diagnosis made?

d) Has your patient suffered previously from this, or from any related condition? ❑ YES ❑ NO

If your answer is yes, please give full details of the related condition and dates on which the related condition first occurred.

e) If your client has suffered an accident, are his or her injuries in any way related to a previous injury? ❑ YES ❑ NO

If your answer is yes, please give full details of the related condition and dates on which the related condition first occurred.

4. PLEASE GIVE FULL DETAILS OF THE TREATMENT YOUR PATIENT HAS RECEIVED

Please state diagnostic tests performed and your reason for the tests

Dates:	Tests performed:	Reason for tests:

Please give full details of the treatment your patient has received

Dates:	Treatment performed:

Has your patient received in-patient or day-patient treatment? ❑ YES ❑ NO

The date of admission to hospital: **The date of discharge:**

5. 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:**

Please print your name and address:

Contact telephone number:

Fax: **Email:**

Qualifications:

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP

GHGEN/07

William Russell Limited

William Russell House,
The Square, Lightwater, Surrey,
GU18 5SS, UK.

Tel: + 44 1276 486455
Fax: + 44 1276 486466

claims@william-russell.com

William Russell (Asia Pacific) Limited

Marketing Office, Suite 16-7, 16th Floor,
Wisma UOA II, 21 Jalan Pinang,
50450 Kuala Lumpur, Malaysia.

Tel: + 6 03 2171 2071
Fax: + 6 03 2171 2072

claimskl@william-russell.com