INTERNATIONAL HEALTH PLAN - CLAIM FORM

ExpaCare

How to claim • Important - Please read carefully

To help us deal with your claim quickly, please:

a. Complete a separate claim for each illness/accident or dental treatment and for each Insured Person.

b. Ensure that the doctor or dentist who treats you fully completes the section overleaf.

c. Send this form, together with the original bills to International SOS **within 90 days of the start of treatment.** If bills are not available, please notify us within 90 days.

d. A FULL WRITTEN REPLY MUST BE GIVEN TO EACH QUESTION, TICKS AND DASHES WILL NOT SUFFICE AND MAY DELAY SETTLEMENT OF YOUR CLAIM.

Please complete in BLOCK CAPITALS and return to:
Expacare Claims Department
Sixth Floor, Landmark House
Hammersmith Bridge Road
London W6 9DP United Kingdom
Telephone: **+44 (0)20 8762 8101**
Facsimile: **+44 (0)20 8762 8072**
24-hour International SOS assistance line **+44 (0)20 8762 8100**

Section A. Patient Information (to be completed by the Insured Person or his/her Legal Representative)

1. Surname (Family name):	2. First Names:
3. Date of Birth:	4. Certificate Number:
5. Nationality on Passport:	6. Sex Male Female
7. Full mailing address of Claimant:	8. Full Name and Address of Employer: (Group Schemes Only)
Contact telephone number: Contact facsimile number: Contact e-mail:	Contact telephone number:

Section B. Client Information (to be completed by the Insured Person or his/her Legal Representative)

9. State Nature of Illness:	10. Date upon which symptoms first occurred

11a. Did you receive treatment (including prescribed medicines) for this condition or any associated condition during the two years prior to joining the plan?

11b. If yes, have you subsequently consulted any doctor for medical treatment or advice (including check-ups) or taken medication relating to this condition. Please give details on a separate sheet.

12. Name and address of your usual physician for the same period:

13. If you have consulted any other physician in any other country during those 2 years please enter their names and addresses:

14. If the cause of the illness relates to an accident, state the date of the accident and give brief details of the circumstances and the injuries received:

15. Please give details of other Health Insurance Coverage:

16. Any further accounts to be submitted? If so, please give details:

17. Is this a continuation of previous or current treatment for which you have already claimed under the Plan? If yes, please give brief details:

18. Date of treatment	List of expenses for which reimbursement is claimed	Currency and amount paid	State to who you wish settlement paid	Currency of settlement

19. I authorise the release of, and consent to the use of, any medical or other information necessary to process this claim. To the best of my knowledge all the details given are true.

Signature of Insured Person or Legal Representative Date

Section C. Medical Information (to be completed by treating Physician or Dental Surgeon only – PLEASE PRINT)

20a. Please state the date at which the patient first consulted you for this or any related condition:

20b. When did the symptoms first occur?

21. Please give name and address of the referring physician: (if applicable)

Contact telephone number

22. Please give your diagnosis of the illness/injury:

23. Does the treatment relate to a birth defect or congenital illness? (Birth defects are deemed to include hereditary conditions).

24. If all or part of the treatment was in respect of elective cosmetic surgery please indicate the amount or proportion of the costs involved.

25. Please give a history of this or any related condition with dates on which any previous treatment took place:

26. Have you any reason to believe that treatment for the same condition has been given previously? If yes, please give details:

27. In respect of claims for Maternity Care please state the expected delivery and the date on which the patient first consulted you for this condition:

28. In respect of claims for Routine Dental Treatment, please advise as follows:

Have you seen this patient for Dental Treatment/Inspection in the past 12 months? YES/NO

If YES was all necessary treatment concluded?

If NO in your opinion has the patient attended for Dental Treatment/Inspection in the past 12 months?

29. Please print your name and address and state your qualifications:

30. I do/do not* wish payment to be made direct to myself

Signature of treating Physician or Dentist Date

* *delete as appropriate*

Data Protection Act 1998. The personal information we collect on this form is necessary to enable us to process your health insurance claim. This information will be passed to International SOS and will be used solely to evaluate your claim.