DENTAL CLAIM FORM

Please complete this form in block capitals using black ink

GLOBAL HEALTH®
Health Insurance for Expatriates

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DUBAI INSURANCE

IMPORTANT – PLEASE READ THESE INSTRUCTIONS CAREFULLY: SECTION A & B MUST BE COMPLETED BY THE CLAIMANT, OR BY THE CLAIMANT'S GUARDIAN OR LEGAL REPRESENTATIVE. SECTION C MUST BE COMPLETED BY THE TREATING DENTIST. WE CANNOT SETTLE YOUR CLAIM UNLESS SECTION C IS FULLY COMPLETED BY THE DENTIST. 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

1. CLAIMANT DETAILS

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/YY)**:**

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 dentist:

Name:

Address:

Telephone: Fax:

Email:

2. COMPLETE THIS SECTION IF YOUR CLAIM IS FOR EMERGENCY DENTAL TREATMENT FOLLOWING AN ACCIDENT

Date you were admitted to hospital (DD/MM/YY)**:**

Date you were discharged from hospital (DD/MM/YY)**:**

Date of the accident (DD/MM/YY)**:**

Please give details of the circumstances of the accident and the injuries sustained:

3. COMPLETE THIS SECTION IF YOUR CLAIM IS FOR ROUTINE DENTAL TREATMENT

Please state your reason for visiting the dentist:

SECTION B To be completed by the claimant or the claimant's guardian or legal representative

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

Please attach the original, fully itemised accounts.

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

2. PLEASE STATE HOW YOU WISH TO BE REIMBURSED

If you have previously submitted a claim, are your payment details the same? ❑ YES ❑ NO/NOT APPLICABLE If YES go to part 3.

❑ **PAYMENT TO YOUR VISA CARD** NB. We can only make payment to a visa card in US Dollars, Euros or Sterling.

Card number:

Name on card:

Expiry date (DD/MM/YY):

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

❑ **PAYMENT TO YOUR BANK ACCOUNT** NB: Payment by bank transfer may be subject to local bank charges.

Currency in which you would like to be reimbursed:

Bank name and address:

Account holder name(s):

Bank account number*: Sort code:

BIC Number*:

IBAN number*:

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

❑ **PAYMENT BY BANK DRAFT** NB: Payment by bank draft is subject to local bank charges. Please allow up to 4 weeks for delivery.

Name of the payee:

Currency of the bank draft:

Address to send draft (If different from Section A):

3. DECLARATION, AUTHORISATION AND CONSENT BY THE CLAIMANT OR HIS/HER LEGAL REPRESENTATIVE

Do you have any other health or dental insurance cover?

❑ NO, I have no other health or dental insurance cover

❑ YES, I have other health or dental insurance cover with:

I hereby declare that, to the best of my knowledge and belief, all information provided in this claim form is accurate and complete. I hereby authorise any dentist, doctor of medicine, hospital or other person who has attended or examined me, to furnish to Dubai Insurance Company psc or to their authorised representative, any and all information with respect to sickness or injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records relating to me (or to the patient if I am the patient's parent/legal guardian).

I accept that my personal details may be passed to selected third parties, such as cost agents and Third Party Administrators, for the sole purpose of assisting with the administration of my claim.

I hereby give Dubai Insurance 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.

Signature of claimant or guardian: **Date** (DD/MM/YY)**:**

Print name of claimant or guardian:

SECTION C To be completed by the claimant's dentist

1. PATIENT DETAILS

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

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

Was the patient referred to you? ❑ YES ❑ NO

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

For how long have you known the patient?

2a. IF YOUR PATIENT'S CLAIM IS FOR ROUTINE DENTAL TREATMENT

Please state their reason for visiting the dentist:

2b. IF YOUR PATIENT'S CLAIM IS FOR EMERGENCY DENTAL TREATMENT FOLLOWING AN ACCIDENT

Please state the date (DD/MM/YY)**:**

The accident occurred: The patient first consulted you:

The patient was admitted to hospital: The patient was discharged from hospital:

State on which basis the patient was hospitalised: ❑ In-patient ❑ Day-patient

Please give details of the circumstances of the accident and the injuries sustained:

Has there been any damage to existing crowns, bridges or artificial teeth? ❑ YES ❑ NO

If YES, please give full details:

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

Please give full details of the treatment your patient has received:

Dates:	Treatment provided:

4. DECLARATION BY DENTIST

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

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

Please print your name and address:

Telephone: **Fax:**

Email:

Qualifications:

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP

NOTE TO CLAIMANT OR GUARDIAN:
Once Sections A, B and C have been fully completed and signed, please send your claim form to our Global Plans Team at the address below.

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