

# GENERAL CLAIM FORM

Please complete this form in block capitals using black ink



**GLOBAL HEALTH**<sup>®</sup>  
Health Insurance for Expatriates



دبي للتأمين  
**DUBAI INSURANCE**

**PLEASE NOTE:** Claims for dental treatment, maternity treatment, the well-being benefit, and compassionate home travel, must be made on their own claim forms which are available at [www.globalplans.ae/webworks](http://www.globalplans.ae/webworks) or by calling +971 4 2697708.

**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 DOCTOR. WE CANNOT SETTLE YOUR CLAIM UNLESS SECTION C IS FULLY COMPLETED BY THE DOCTOR. 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 personal physician (General Practitioner):**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### 2. DETAILS OF THE CONDITION BEING TREATED

**Please describe your symptoms:** \_\_\_\_\_

**When were you first aware of your symptoms (DD/MM/YY)?** \_\_\_\_\_

**When did you first consult a doctor with regard to these symptoms (DD/MM/YY)?** \_\_\_\_\_

**What is your doctor’s diagnosis?** \_\_\_\_\_

**Have you ever suffered from this or any related condition before?  YES  NO** If YES, when did you suffer from this or the related condition? \_\_\_\_\_

**Is your claim related to injuries sustained in an accident?  YES  NO** If YES, please provide details of the accident and injuries sustained: \_\_\_\_\_

## 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 PATIENT OR HIS/HER LEGAL REPRESENTATIVE

Do you have any other health insurance cover?

NO, I have no other health insurance cover  YES, I have other health 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 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 doctor

### 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: \_\_\_\_\_

### 2. DATES

Please confirm the date the patient first registered at your facility (DD/MM/YY): \_\_\_\_\_

On which date did the patient first consult you for this particular condition? (DD/MM/YY) \_\_\_\_\_

Please give a short description of your client's symptoms or injuries, if they have suffered an accident: \_\_\_\_\_

In your professional opinion, for how long before this date would the patient have been aware of their symptoms? \_\_\_\_\_

### 3. YOUR DIAGNOSIS

What is your clinical diagnosis?

Please advise tests performed and attach test results:

### 4. YOUR TREATMENT PLAN

Please provide a treatment plan including details of medications currently being prescribed to this patient:

### 5. MEDICAL HISTORY

Please answer each of the following questions:

1. Has your patient previously suffered from this or from any related condition?  YES  NO

If YES, please give full details of the previous condition/related condition, and the dates on which it first occurred:

2. Does your patient have a history of any of the following: YES NO Details and date of onset:

High blood pressure, high cholesterol, heart or circulatory disorders?

Diabetes?

Asthma, respiratory or allergic conditions?

Spine, bone, joint or muscle conditions?

Cancer?

Psychiatric, psychological or mental disorders?

Any other disease or injury requiring in-patient treatment?

### 6. 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 (DD/MM/YY):

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 the Global Plans Team at the address below.