

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: _____ Expiry date (DD/MM/YY): _____

Name on card: _____

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 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 claimant if I am the claimant'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: _____

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 regarding this pregnancy (DD/MM/YY)? _____

What is the expected delivery date (DD/MM/YY)? _____

What was the date of the last monthly period (DD/MM/YY)? _____

3. FURTHER INFORMATION

Please state diagnostic tests performed, the test results and your reason for performing the tests.

Date(s) of treatment:	Tests performed:	Reasons for tests:

Are you aware of any complications that may arise during this pregnancy? YES NO

If YES, please provide details:

4. MEDICAL HISTORY

Please answer each of the following questions:

A. Has the patient ever received IVF or any other treatment to assist fertility? YES NO

B. Is this pregnancy as a result of IVF or assisted fertility? YES NO

C. Has the patient previously been treated or hospitalised for any termination of pregnancy, miscarriage, complications of pregnancy, or birth? YES NO

D. 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?	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma, respiratory or allergic conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
Spine, bone, joint or muscle conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric, psychological or mental disorders?			
Any other disease or injury requiring in-patient treatment?	<input type="checkbox"/>	<input type="checkbox"/>	

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 (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.