

MEDICAL CLAIM FORM

To be submitted with original receipt(s) and/or reports

SECTION A (To be completed by the Insured Person)

Name of patient: _____

Policy number: _____

Member number: _____

Declaration

I hereby declare that all information provided on this form and the documents submitted herewith is true and correct to the best of my knowledge and belief. The amounts claimed are the actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source.

Authorization for Release of Information

I authorise any doctor, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to the Insurer ("the Company") any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefor. If this claim relates to an accident, past or present, I also authorise any governmental body, agency, or other person or organisation who may have records pertaining to such accident to release such records or information.

I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organisation(s) performing business or legal services in connection with my claim, save as may be required by law.

I agree that a photocopy or facsimile of this release shall be as effective as the original.

Insured Person's Signature & Date

SECTION B (To be completed by the attending physician)

1) Diagnosis of condition treated: _____

2) Underlying cause: _____

3) When did the symptoms first arise (dd/mm/yyyy): _____

4) Is further treatment required? Yes No

If yes, please give treatment plan _____

If this visit included diagnostic procedures (please provide results and reports), vitamins, vaccines, injections and/or other services, please ensure you provide a full breakdown of the costs (if not already provided on the receipt)

Physician's Signature & Date

Disclaimer: GlobalHealth Asia aims to settle all claims quickly and efficiently. In some cases however, we may require further information than is requested on this form.

Send this form and any supporting documents to:

GlobalHealth Asia Limited

Suite 1401-3 Chinachem Hollywood Centre,
 1-13 Hollywood Road, Hong Kong, SAR

Claims Enquiries: (852) 2187 3664 **Fax:** (852) 2526 0769

Claims Email Enquiries: universalclaims@globalhealthasia.com