

## Authority & Release Form for Direct Billing Service

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

Policy Number: \_\_\_\_\_

We/I authorize GlobalHealth Asia Limited to release the names, dates of birth, sex, passport and/or identification number, any information provided on the Application and any records GlobalHealth Asia Limited may have regarding the Insured Person(s) shown on the Namelist to hospitals, clinics, laboratories, physicians, specialists, dentists, chiropractors, acupuncturists, physiotherapists, or other medical practitioners for the purpose of providing direct bill paying services for the Insured Person(s).

By signing this Authority and Release Form, we/I also acknowledge the specific Policy term listed below:

### Right of Recovery

In the event of authorization of payment and/or payment is made by the Company for a claim which is not covered under this Policy or when the limit of liability of this insurance is exceeded, the Company reserves the right to recover the said sum or excess from you.

This recovery includes but is not limited to deducting the payments owed from other claims made by you during the Policy period. If the amount owed remains outstanding for more than 90 days, then GlobalHealth Asia Limited reserves the right to suspend the direct billing service to you without further notice.

Subject otherwise to the terms, conditions and exclusions of the Policy.

**Signature**  
**Printed Name/Title**

**Date**

*Please note: Direct billing service will be effective 30 days after policy issuance with full payment.*

<b>For Office Use Only</b>			
Provider: _____			
Plan Type: _____	For Addition <input type="checkbox"/>	Notified on: _____	
	For Deletion <input type="checkbox"/>	Notified on: _____	
Administrator: _____			
_____			

### GlobalHealth Asia Limited

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