HEALTH INSURANCE CLAIM FORM

POLICYHOLDER (Company/Individual) Written in BLOCK letters or typed.

Name:	
Address:	POLICY NUMBER:
	FAMILY / MEMBER ID:
Tel No:	EMAIL:

CLAIMANT / PATIENT (If different from above)

Name (in full):

Age: NIC No: Profession or Occupation:

Home Address:

Phone No: Mobile Phone No: Email:

ALL QUESTIONS MUST BE ANSWERED OR THE CLAIM WILL BE REJECTED.

Claim is for: **(ONE claim form per treatment/illness/and per patient)**

- ☐ Optical: Glasses, eye correction, optician...
- ☐ Dental: Dentist, Orthodontist...
- ☐ Out-Patient: Consultations, investigations, prescriptions, therapies and treatment.
- ☐ In-Patient: Investigations, operations and treatments relating to ONE condition or childbirth.
- ☐ Antenatal care
- ☐ Other:

1. Reason(s) for consultation? The symptom(s) or problem(s) that led the Claimant / Patient to seek treatment.	
2. Please provide: a) Name, address and Tel No of the doctor who attended you. (If not CLEARLY indicated on the documents.) b) Treating Doctor's Diagnosis	
3. If the claim is consequent upon an accident, please state the date and give full details of the accident. If you were involved in a road accident, please also provide registration numbers of the vehicles, name of third party's Insurer and the Police station where the accident was reported.	
4. If there is any other insurance or provident fund covering this illness or injury, please give all relevant details.	
5. Is the treatment in connection with this illness or injury now completed? If NO, do you intend submitting additional claim(s) for this illness or injury?	YES / NO YES / NO

HTH025

DETAILS OF DOCUMENTS INCLUDED

ALL documents must be Originals where possible.
If any document is missing or *unreadable*, the claim will be *rejected*.
YOU must make sure that the doctors, other therapists and pharmacists write clearly.

IN-PATIENTS

	All documentation, investigations, treatments and a **Medical Report** about your admission.

OUT-PATIENTS

	Doctors receipt(s)/report stating the diagnosis CLEARLY. Writing must be readable.
	Doctors prescription(s).
	Pharmacy receipts. Typed or CLEARLY written.
	Doctors request letter for ALL tests done.
	Doctors referral letters for physiotherapy or other therapies.
	Breakdown of costs of all blood tests and other investigations.
	Optical: Optician's prescription for new lenses, replacement or else.
	Dental: Detail of procedure(s) done INCLUDING detail of tooth or teeth repaired.
	Please list any other relevant documents below.

Please find attached .... bills amounting to Rs .... being claimed for above treatment.
(Should you wish to receive your out-patient claim settlement by Electronic Fund Transfer, please contact our Health & Travel Department on phone No. 207 3500).

I/we declare the above particulars are true and correct and undertake to give every assistance within my/our power to deal with this claim.

I hereby authorise my general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Swan General Ltd or their appointed representatives.

I/we understand and accept that in case there is any doubt about this claim, Swan General Ltd reserves the right to have the claimant/patient cross examined by another medical practitioner of its choice.

Date: ....

Policyholder's signature **Claimant's signature**

For office use by Swan's Medical Officer