DENTAL CLAIM FORM

Please complete this form in block capitals using black ink

GLOBAL HEALTH®
Health Insurance for Expatriates

PLEASE COMPLETE THIS FORM AND SUBMIT TO US ALONG WITH ITEMISED RECEIPTS FOR YOUR DENTAL TREATMENT. ALL CLAIMS MUST BE SUBMITTED WITHIN 6 MONTHS OF THE DATE OF THE FIRST CONSULTATION.

1. CLAIMANT DETAILS

Full name of claimant:

Title: Mr/Mrs/Miss/Ms/Dr **Date of birth** (DD/MM/YYYY)**:** **Sex:** ❑ **Male** ❑ **Female**

Global Health plan policy number:

Full mailing address:

Telephone:

Email (Failure to provide your email address may result in a delay in processing your claim)**:**

2. COMPLETE THIS SECTION IF YOUR CLAIM IS FOR EMERGENCY DENTAL TREATMENT FOLLOWING AN ACCIDENT

Date you were admitted to hospital (DD/MM/YYYY):

Date you were discharged from hospital (DD/MM/YYYY):

Date of the accident (DD/MM/YYYY):

Please give details of the circumstances of the accident and the injuries sustained:

3. 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:

4. PLEASE STATE HOW YOU WISH TO BE REIMBURSED

❑ **PAYMENT TO YOUR VISA CARD** NB: We can only make payment to a visa card, and settlement can be provided in Sterling, Dollars or Euros. If your previous claim reimbursement was made to a credit card, you will need to recomplete the details below as, for security purposes, credit card information is not stored.

Card number:

Name on card: Expiry date (DD/MM/YYYY):

Address to which card is registered (If different from part 1):

❑ **PAYMENT TO YOUR BANK ACCOUNT**

If you have previously submitted a claim, are your payment details the same? ❑ **YES** ❑ **NO** ❑ **NOT APPLICABLE**

If YES go to part 5. If no, please provide your account details below:

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*:

5. DECLARATION AND AUTHORISATION

Do you have any other insurance cover?

❑ No, I have no other health insurance cover ❑ Yes, I have other health insurance cover with: _____

I hereby give William Russell Limited 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.

Name of patient: **Date of birth (DD/MM/YYYY):**

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WilliamRussell
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