MATERNITY CLAIM FORM

Please complete this form in block capitals using black ink

GLOBAL HEALTH®
Health Insurance for Expatriates

IMPORTANT – PLEASE READ THESE INSTRUCTIONS CAREFULLY: SECTION A & C MUST BE COMPLETED BY THE CLAIMANT, OR BY THE CLAIMANT'S GUARDIAN OR LEGAL REPRESENTATIVE. SECTION B MUST BE COMPLETED BY THE TREATING DOCTOR. WE CANNOT SETTLE YOUR CLAIM UNLESS SECTION B IS FULLY COMPLETED BY THE DOCTOR.

SECTION A: To be completed by the claimant or the claimant's guardian or legal representative

1. CLAIMANT DETAILS

Full name of Global Health policyholder: **Title: Mr/Mrs/Miss/Ms/Dr**

Full name of claimant (If not the policyholder)**:** **Date of birth** (DD/MM/YY)**:**

Global Health plan policy number:

Full mailing address:

Telephone: **Fax:**

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

Please state the name and address of your personal physician (General Practitioner):

Name:

Address:

Telephone: Fax:

Email:

2. DETAILS OF YOUR PREGNANCY

On what date did you discover that you were pregnant (DD/MM/YY)**?**

Please provide the name of the medical professional that confirmed that you are pregnant:

What is your estimated due date (DD/MM/YY)**?**

Please confirm how many previous pregnancies you have had:

At which hospital do you plan to give birth?

Do you plan to give birth by Caesarean Section? ❑ YES ❑ NO

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/YY):

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*:

* BIC and IBAN details are necessary for all transfers to European and UAE bank accounts. BIC and bank account number are necessary for all transfers to international bank accounts.

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):

Claim reference:

Signature of patient: **Date:**

PLEASE ENSURE YOU REMEMBER TO SIGN THE CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM AT THE END OF THIS DOCUMENT. FAILURE TO DO SO WILL DELAY YOUR CLAIM.

SECTION B :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:

Was any medication prescribed? ❑ **YES** ❑ **NO** If YES, please indicate the medication and the reason for it's prescription.

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 suffered any complications during childbirth? ❑ **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?	❑	❑	
Diabetes?	❑	❑	
Asthma, respiratory or allergic conditions?	❑	❑	
Spine, bone, joint or muscle conditions?	❑	❑	
Cancer?	❑	❑	
Psychiatric, psychological or mental disorders?	❑	❑	
Any other disease or injury requiring in-patient treatment?	❑	❑	

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:

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WilliamRussell
Expatriate Insurance Specialists

SECTION C: To be completed by the claimant or the claimant's guardian or legal representative

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM

WilliamRussell
Expatriate Insurance Specialists

In order to consider your claim, we will need to obtain copies of your medical records and /or medical reports from doctors and other medical service providers. We can only obtain these with your consent and therefore need you to complete the Declaration below.

However, under the Access to Medical Reports Act 1988, you have certain rights in relation to reports requested by us which have been prepared by your doctor(s) and these are summarised as follows:

1. You can indicate in the attached Consent Declaration that you do not wish to see the report or records before they are sent to us. The doctor(s) or other medical service provider(s) that have treated you or are planning to treat you will then send the report directly to us.

2. You can indicate in the attached Consent Declaration that you do wish to see the report or records before they are sent to us. We will then inform you when we contact your doctor(s) or other medical service provider(s), at the same time that we contact him/her/them and you will have 21 days to contact him/her/them to make arrangements to do so. Should there be any charge for providing you with a copy of the report or records it will be your responsibility to pay the charge. When you have seen the report or records you will need to give your consent to the doctor(s), or other health service providers, before the report or records are sent to us. If you do not contact your doctor, or other health service provider, within 21 days, the report will be sent to us.

You can ask your doctor if he/she will amend any part of the report or records which you consider to be incorrect or misleading. If your doctor is not in agreement, you may attach your comments before it is sent to us.

3. You can withhold your consent. However, if you withhold your consent we will be unable to proceed with your claim.

Your doctor(s) or other health service provider(s) are entitled to withhold from you some or all of the information contained in the report or records if (a) they consider that it may be harmful to you, (b) it would indicate their intentions in respect of you, or (c) it would reveal the identity of another person without their consent.

Your personal information will be processed by William Russell Limited in accordance with The Data Protection Act 1998.

DECLARATION AND AUTHORISATION

I have been informed of and understand my rights under the Access to Medical Reports Act.1988.

I hereby authorise any doctor of medicine, hospital or other health professional who has attended or examined me, to furnish to William Russell Ltd or to its authorised representative any and all information with respect to illness or injury, medical history, consultation, prescriptions, medical investigations or treatment and copies of all hospital records and/or medical records.

❑ I wish to see a copy of the report or records before they are sent to William Russell Limited

❑ I do not wish to see a copy of the report or records before they are sent to William Russell Limited

A photocopy, scanned copy or facsimile of this authorisation shall be considered as effective and valid as the original.

I consent to use of the information by William Russell Limited for the purpose of data processing (electronic or otherwise); assessing my claim(s); medical underwriting; and disclosure to other doctors or health professionals involved in my treatment or care, to William Russell limited's medical officers and emergency assistance service providers (including those based outside the European Union), to my health insurers and reinsurers and to the policyholder (if other than myself).

Name of patient:

Date of birth (DD/MM/YY):

Claim reference:

Signature of patient: **Date:**

The following section should be completed by the patient's parent or guardian if the patient is a child under 16 years of age, or by the patient's next of kin if the patient is unable to provide properly informed consent due to cognitive disability, or if the patient is deceased.

Name of signatory (please print):

Relationship to patient:

Address

Date:

NOTE TO CLAIMANT OR GUARDIAN:
Once Sections A, B and C have been fully completed and signed, please send your claim form to our International Claims Team at the address in the United Kingdom below.

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