AL-BUHAIRA NATIONAL INSURANCE COMPANY

P.O. BOX 6000
SHARJAH, U.A.E.
Tel.No. 06-5680505, Fax No. 06-5696636

MEDICAL EXPENSES CLAIM FORM

To be completed by Medical Attendant
In order to establish a claim it is essential that the **Medical Attendant** of the Claimant should complete this form as fully as possible. Any fee charged for this certificate is not covered by the Policy.

1. Claimant's Name ..... Age .....

2. ACCIDENT / SICKNESS

(a) Precise nature and extent thereof :.....

(b) Its origin and cause :.....

3. How long have you been the Claimant's usual medical attendant ? ..... Are you still attending ? **YES** ..... **NO**	4. Date you first saw the Claimant in connection with this accident or illness ..... If still attending, date last seen .....
5. Has the Claimant previously suffered from the above trouble ? **YES** ..... **NO** ..... If the answer is **"YES"** state (i) Its nature .... (ii) The period/s involved	6. Has the Claimant previously suffered from any other accident or illness which affects the present disablement ? **YES** ..... **NO** ..... If the answer is **"YES"** state (i) Its nature .... (ii) The period/s involved .....

7. If any of the following is required, please specify type of test and reason

a) Laboratory .....

b) Radiology .....

c) X-Ray .....

8. (a) Has the claimant fully recovered from Accident/Sickness **YES**..... **NO**.....

(b) If **"NO"** state details of further treatment required .....

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9. **REMARKS** .....
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I certify that I have satisfied myself by personal examination that all the foregoing statements are accurate and correct.

Signature .....**Qualifications**.....
(attending physician)

Address .....**Date**.....

Name of Employee: ..... Name of Employer. .....

Patient's Name: ..... **I.D. No.** : .....

Signature: ..... Date : .....