



# expacare

GLOBAL HEALTHCARE AND ASSISTANCE



**Making a claim leaflet & claim form**

[www.expacare.com](http://www.expacare.com)

## Making a claim

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We recommend that you phone us before you start any treatment, so we can confirm the extent of your cover and help you through the claims process. There are some benefits that you need to get pre-authorisation such as psychiatric treatment if you have that cover, or emergency medical evacuation.

And if you are a Valuecare member, you must get our pre-authorisation before you have any inpatient or day-patient treatment in hospital.

If you haven't yet registered with a doctor and need help finding one, you can phone us.

## Emergency medical evacuation claims

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Your plan provides cover for emergency medical evacuation from a land mass (and medical care while you are being transported to the medical facility) to move an insured person who has a critical medical condition to the most suitable medical facility, if that facility is not available locally. If you have a critical medical condition and need emergency medical treatment that is not available locally, please follow these steps.

Contact our Assistance Centre before you make any travel arrangements so that we can pre-authorise and guarantee the payment for you. We are available to help you 24 hours a day, seven days a week:

Telephone: +44 (0) 20 8762 8100

Please have the following information ready.

- › Your name, date of birth, nationality, current address and phone number.
- › Your membership number.
- › The medical problem or the help you need.
- › The date of the illness or accident.
- › The name and phone number of any doctor treating you.

Assistance centre staff will advise you what to do and make necessary travel arrangements. They will also make arrangements for hospital admission at the approved destination.

## Completing the claim form

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- › Please complete a separate claim form for each unrelated medical condition and for each insured person.
- › Please ask your doctor or dentist to complete their section.
- › Please keep a copy of your claim form and any accounts for your records.
- › You can detach and retain this sheet for future reference.
- › You must send us the form within 6 months of the start of treatment.
- › Where an excess or co-insurance applies we will take it off the settlement and show the calculations in our letter to you.
- › If you receive any more accounts for the same claim after you have sent in your claim form, send the original documents to us with a covering note, and ensure you keep copies for your records.
- › Send the original documents (claim form and accounts) to:

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### Within the Middle East:

Neuron LLC.  
P.O. Box 72071  
Dubai,  
UAE

Telephone: 800 44 08 (freephone within the UAE 7 days per week)  
+9714 329 0515 (within the Middle East)  
+971 (0)50 551 9102  
(in emergencies only from 9pm to 9am UAE time)

Fax: 04 332 6888

Email: [expacareclaims@neuron.nu](mailto:expacareclaims@neuron.nu)

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### Outside of the Middle East:

Expacare Claims  
Sixth Floor  
Landmark House  
Hammersmith Bridge Road  
London W6 9DP  
United Kingdom

Telephone: +44 (0) 20 8762 8101

Fax: +44 (0) 20 8762 8072

Email: [expacareclaims@internationalsos.com](mailto:expacareclaims@internationalsos.com)

For our 24-hour emergency helpline, please contact: +44 (0) 20 8762 8100

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**Please make sure all sections are completed and remember to sign the form, keep copies for your records  
and send it to us within six months of the start of treatment to the appropriate address above.**

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## 1. Patient Information

Insured person's full name:

Title:

Nationality:

Membership number:

Date of Birth (DD/MM/YY): DD / MM / YYYY

Address:

Is this a recent change of address? No  Yes

Telephone number:

Fax number:

Would you like to receive your claim statement(s) by email? No  Yes

Email address:

*Please only select this option if you agree to our sending you information about your medical condition, treatment and benefits paid, by unencrypted email.*

## 2. Your Claim

Is this your first claim for this medical condition? No  Yes

Are you claiming for cash benefit? No  Yes

Is this an initial request to find out if your claim is covered before you start treatment? No  Yes

*If yes, please get **all sections** completed and send or fax this form to us at the address at the top of this form. We will let you know the extent of your cover by return.*

Please describe the medical symptoms or event you want to claim for:

Diagnosis (if known):

How long have you had these symptoms before consulting your doctor?

Please supply:

Dates of treatment	List of expenses you are claiming for	Currency and amount paid	Who would you like us to pay?	Preferred currency <small>(we will do our best to oblige you)</small>

Are you injured or ill as a result of an accident, (e.g. a road accident or accident at work) or are you considering making a personal injury claim against someone else? No  Yes

Do you have any other insurance for this type of claim, like travel insurance? No  Yes

How many accounts are enclosed?

What is their total value?

Will further accounts follow? No  Yes

*Please enclose original accounts (not receipts or photocopies) with this form. We will keep these for audit purposes so please make copies for your records.*

If you would like us to pay some or all of the settlement directly into your account please give us the:

A/c number:

A/c name:

Sort code:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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or Swift Code:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Bank Name:

Branch Name:

Bank Address:

*If you receive any more accounts following on from this claim, simply complete the continuation form that we will include with your settlement letter*

## 3. Insured Member's declaration

I declare that to the best of my knowledge and belief the information given on this form is true and complete. I hereby authorise any doctor or hospital to release such medical information as the Insurer, or its authorised Claims Administrator, may require for assessing my claim under this Insurance Plan.

Signature:

Date (DD/MM/YYYY): DD / MM / YYYY

*By signing this form you are confirming that you have read the terms of this plan including the data protection section in the membership guide and understand them. If you have any doubts, please telephone us.*

#### 4. To be completed by your Doctor or Specialist

*This section is only admissible if it is completed by the specialist or referring doctor and who is registered and licensed to practise in the country where you receive treatment. We reserve the right to withhold benefit for treatment by doctors who do not hold internationally recognised qualifications and training (for example, a medical school listed in the World Health Organisation's World Directory of Medical Schools).*

Please indicate the initial diagnosis and description of symptoms:

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Please tell us when the patient first consulted a doctor for this or similar symptoms?

Has the patient received any treatment, had any need for treatment or required medication and/or advice in the past 2 years for this condition? No  Yes

To whom are you referring this patient?

Name:

Specialisation:

Date Referred:

What is the likely treatment plan and procedure to be performed?

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*Hospital admission must be pre-authorized by us.*

Name of hospital:

Proposed admission date:

Address of hospital:

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Expected hospital stay:

#### Declaration:

I hereby certify that I am the patient's doctor.

Signature:

Date (DD/MM/YY): DD / MM / YYYY

Telephone number:

Name and Address or practice stamp:

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#### Section 5: For dental claims

**(Dental benefits are not available under all plans, please see your insurance certificate)**

*This section may only be completed by a dentist who is trained, qualified, and licensed to practise dentistry by the licensing authority of the country in which you receive treatment.*

Have you or another dentist seen this patient in the last 12 months?

If yes, was all necessary treatment concluded?

Please describe dental necessity for this claim:

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*If this is a claim for restorative treatment after an accident, we will write to you requesting the information we need.*

Signature of dentist:

Date (DD/MM/YY): DD / MM / YYYY

Contact telephone number:

Name and Address or Practice Stamp

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**Please make sure all sections are completed and signed before sending to us.**

**Please contact us if you are uncertain which address is appropriate before returning the form.**