

Please ensure Your claim form is completed in full and returned within six months of Your initial Treatment. Failure to complete Your form in full will result in the form being returned to You and will hold up the processing of Your claim. Please note Goodhealth is not responsible for any costs associated with the completion of this form or for any further information/documents requested by Us to assess Your claim. The issuing of this claim form is in no way an admission of liability.

Policyholder

Policy Number

Section A: Patient's Details - To be completed by the member

Surname:

Address:

First Name & Initials:

Date of Birth:

Email:

Contact Telephone Number:

Fax/Mobile:

Do you hold any other insurance? Yes No

Were Your injuries caused by an accident? Yes No

If Yes, please provide full details on a separate sheet

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Section B: Claims Settlement - To be completed by the member

Total amount claimed, including currency of claim:

If settlement is to be sent care of Your bank or by transfer, please give full details including name and address of the bank, account name and number and sort code:

Currency in which You wish settlement to be made:

State to whom You wish settlement to be made, if different to the member:

Address to where settlement to be sent:

Please note payment may not have been credited to Your bank account at the time You receive your Advice from Us. You will need to check with Your bank.

Section C: Declaration

"I declare that all information, to the best of my knowledge, provided on this claim form is truthful and correct. I also understand that this declaration gives permission to Goodhealth and their appointed representatives to approach any third party for information required to complete their assessment of this claim including, but not limited to, my current and previous Medical Practitioners."

"I declare and agree that the personal information collected or held by Goodhealth, whether contained in this form or otherwise obtained may be used by Goodhealth, or disclosed or transferred to any organisation for the purpose to (1) assess this claim and to provide on-going insurance and customer services, (2) process and give effect to Credit Card Payment, (3) provide marketing material in respect of insurance related services of Goodhealth or its associated companies and (4) process claims or analyse the insurance."

Patient's Signature:

Date:

(If patient is under 18 years of age, Parent or Guardian must sign)

Section D: Claims Information - To be completed by the Patient's Medical Practitioner or Dental Practitioner

Details of Medical Condition requiring Treatment: *(Please provide the precise diagnosis, if known).*

Underlying cause:

If this claim is for maternity please advise whether the pregnancy is as a result of any form of assisted conception:

How long has this condition been in existence:

When did the patient first become aware of any symptoms prior to seeking medical Advice?

Date of first consultation with any practitioner for this condition:

Has this, or any similar condition previously been suffered from?

Please confirm the likely period of Treatment & prognosis (if known):

Name & Address of referring Doctor/Dentist:

Please complete only if the patient has been referred to You

Please detail any diagnostic tests performed and attach the results:

This question relates to Dental Treatment only Is this claim for a routine check-up? Yes No

If you have Insufficient space in any section, please provide full details on separate sheet

Section E: Medical Practitioner or Dental Practitioner Details - To be completed by the Patient's Medical Practitioner or Dental Practitioner

Name of Practitioner:

Official Stamp

Address of Practitioner:

Tel:

Fax:

Email:

Practitioner's Signature:

****IMPORTANT**** - Please ensure

- | | |
|--|---|
| 1 All original receipts and prescriptions are attached | 5 The diagnosis and underlying cause have been confirmed |
| 2 The claim form is completed in full | |
| 3 The declarations are signed and dated | This will ensure that your claim is reviewed in a timely fashion. |
| 4 All laboratory tests are attached | |

Date: / /

Important Note - Please ensure that all costs for non-emergency **In-Patient/Day-Patient Treatment**, all **MRI & CT Scans**, are agreed by **Us**, or **Our Helpline**, in writing (Fax/Mail/Letter) before any planned **Treatment** is undertaken. Planned **Treatment** undertaken without pre-authorisation from **Us** will not be covered. A verbal confirmation does not constitute pre-approval. If in doubt, please contact the Medical Helpline, as shown on **Your Membership Card**.

Planned In-Patient & Day-Patient Treatment

In the event of a planned admission on an **In-Patient** or **Day-Patient** basis to a **Hospital**, the following steps must be taken. Payment of all expenses incurred by **You** will not be recoverable unless **You** follow these procedures.

- i) Contact **Our Medical Helpline** as soon as reasonably possible prior to admission giving full details of the condition, proposed **Treatment** including dates and name of procedure (if known) together with the name of the **Specialist** and **Hospital** details. (The telephone number is provided on the back of **Your** membership card.)
- ii) The Medical Helpline will advise **You** if they have sufficient information to confirm **Your** cover. If not, they will advise **You** what further information is required.
- iii) When sufficient information has been made available to appraise **Your** claim, the Medical Helpline will verbally confirm the basis of **Your** cover and will despatch written confirmation to **You**.

iv) The Medical Helpline will attempt at all times to make arrangements with the **Hospital** for all eligible bills to be settled directly. Where this has been arranged **You** should send the original claim form and any unpaid invoices (if given to **You** by the **Hospital**) to **Your Goodhealth Claims Service**.

v) Please ensure a new/separate claim form for each member, each new **Medical Condition** and each admission to **Hospital** is submitted.

Out-Patient Treatment

If **You** receive medical **Treatment** as an **Out-Patient**, outside of **Our Provider Network Treatment** must be paid for in full by **You** at the time of the appointment and re-claimed from **Us**. In such circumstances please ensure that a claim form is completed by **You** and the **Medical Practitioner** or **Specialist**. Please remit this to **Your Goodhealth Claims Service** with all substantiating proof of **Your** claim, including, but not limited to, the original invoice(s) and proof of payment, prescription and a written diagnosis from the **Medical Practitioner**.

Please return **Your** claim form to one of the following offices:

For residents of Middle East, Africa and Indian sub-continent:

Goodhealth Claims Service	T: +971 4 324 0040
Suites 416	F: +971 4 324 3550
Oud Metha Building	E: claims@goodhealth.ae
PO Box 6380	
Dubai	

For residents of Far East and Pacific Rim:

Goodhealth Claims Service	T: +852 2866 8000
3204 32/F Admiralty Centre	F: +852 2866 2555
Tower 1	E: claims@goodhealth.com.hk
18 Harcourt Road	
Hong Kong	

For residents of Europe and Rest of World:

Goodhealth Claims Service	T: +44 870 442 4386
PO Box 34421	F: +44 870 442 4387
London	E: claims@goodhealth.co.uk
W6 9UR	
UK	

www.goodhealthworldwide.com