William Russell

General Claim Form

Please complete Section A of this claim form. If the total amount of your claim is going to exceed US$500 (or the equivalent in another currency), please ask your physician to complete Section B of this form.

Submit the completed form, with the fully itemised invoices for all treatment you have received, to claims@william-russell.com

In some cases we may require your physician to complete Section B, even if your claim is for less than US$500.

We can only reimburse your claim when we have received copies of the fully itemised invoices, which give us a complete breakdown of all treatment you have received and any medication you have been prescribed.

We also reserve the right to request original documentation relating to your medical treatment, so please retain all original invoices and receipts for a period of 12 months.

Section A

Section A is to be completed by the claimant, or the claimant's guardian or legal representative.

Claimant's personal details

Name: ..... Surname: ..... Title: .....

Address: .....

.....

Plan number: ..... Date of birth: .....

Email: ..... Telephone number: .....

Details of condition being treated

Please describe your symptoms: .....

.....

.....

When were you first aware of your symptoms? .....

When did you first consult a physician with regard to these symptoms? .....

What is your physician's diagnosis? .....

.....

Have you ever suffered from this or any related condition before? ◯ Yes ◯ No

If **YES**, when did you suffer from this or the related condition? .....

Is your claim related to injuries sustained in an accident? ◯ Yes ◯ No

If **YES**, please provide details of the accident and injuries sustained: .....

.....

Please list the bills for which you are seeking reimbursement

Date(s) of treatment	Details of the bills you have enclosed for reimbursement	Currency and amount paid

How you wish to be reimbursed

If you're instructing us to pay your claim in a currency other than the currency you pay your premiums in, we won't be responsible for losses due to exchange rate fluctuations. If we're making a payment for multiple invoices that you've submitted, we'll use the exchange rate for the date stated on the final invoice during your period of cover. If the invoices fall in two periods of cover, we'll use the date stated on the final invoice during each period of cover.

◯ **Payment to your credit card**

Currency in which you would like to be reimbursed: ◯ US dollars ◯ Pounds sterling ◯ Euros

If you are paying your premium by credit card and you wish to be reimbursed to the same card, please confirm the last four digits of your credit card number: .....

Otherwise, you will need to complete our reimbursement form.

◯ **Payment to your bank account**

Currency in which you would like to be reimbursed: ◯ US dollars ◯ Pounds sterling ◯ Euros ◯ Other: .....

If you have previously submitted a claim, and you wish to receive reimbursement to the same bank account as before, please confirm the last four digits of your account number: .....

If you have not submitted a claim before, or you have submitted a claim before and you wish to receive reimbursement to a different bank account, please provide your account details below:

Bank name and address: .....

.....

..... Account holder name(s): .....

Bank account number*: ..... Sort code: .....

IBAN number*: ..... BIC 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.*

Declaration and authorisation

Do you have any other health insurance cover? ◯ Yes ◯ No

If YES, please state the insurance provider and your policy number: .....

Provider's email: ..... Provider's telephone: .....

Are you entitled to benefits under any state-funded medical care scheme, and/or do you hold a Global/European Health Insurance Card (i.e., GHIC or EHIC)? ◯ Yes ◯ No

I hereby give William Russell 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.

I consent to the use of this information by William Russell for the purpose of: data processing, electronic or otherwise; assessing my claim(s); medical underwriting; and for disclosure to other medical professionals involved in my treatment or care, to William Russell's medical officers and emergency assistance service providers (including those based outside the EU), to my medical insurers and reinsurers, and to the plan holder if other than myself. If required, we will pass your information to legal and regulatory bodies, and we may pass information to relevant third parties in the interests of fraud and money-laundering prevention.

I also authorise any physician, doctor or medicine, or any other health professional who has attended or examined me to furnish William Russell and/or its authorised representatives any and all information with respect to my medical condition(s), illnesses and injuries, medical history, consultations, prescriptions, medical investigations, tests and treatment, and copies of all hospital/medical records.

Name of claimant*: ..... **Date of birth:** .....

Signature of claimant: ..... **Date:** .....

This should be completed by the claimant's parent or guardian **if the claimant is a child under age 16, or by the claimant's next of kin if the claimant is unable to provide properly informed consent due to cognitive disability or otherwise, or if the claimant is deceased. Please also state your relationship to the claimant and provide contact information.*

Section B

Section B is to be completed by the claimant's physician.

Patient's details

Full name: ..... Date of birth: ..... ◯ Male ◯ Female

Was the patient referred to you? ◯ Yes ◯ No

If **YES**, please state the name and contact details of the referring physician: .....

.....

Dates of treatment received

Please confirm the date the patient first registered at your facility/practice: .....

On which date did the patient first consult you for this particular condition? .....

Please give a short description of the patient's symptoms/injuries: .....

.....

In your professional opinion, for how long before this date would the patient have been aware of their symptoms? .....

.....

Has the patient previously suffered from this or from any related condition? ◯ Yes ◯ No

If **YES**, please give full details of the previous condition/related condition, and the dates on which it first occurred: .....

.....

Your diagnosis

What is your clinical diagnosis? .....

Please give details of any tests performed and attach the test results: .....

.....

Your treatment plan

Please provide a treatment plan including details of medications currently being prescribed to the patient: .....

.....

Declaration by physician

I declare that I am the patient's treating physician, and that the details given above are full, true, accurate, and complete.

Signature of physician: ..... **Date:** .....

Print your name and address: .....

Qualifications: ..... Email: .....

Telephone number: ..... Fax number: .....

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP:

Contact Details
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E claims@william-russell.com
william-russell.com

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