Claim Form

Please send completed form to **claims.uae@hayah-april.com**

Complete Sections A and B, and sign Declaration if:

- You are claiming only for outpatient doctor visits, medications, dental and general laboratory tests
- The doctor has written the diagnosis on the bill or receipt, or on a separate note, and
- You have not been advised you may require surgery, hospitalisation, or specialised testing for this disability

Complete Sections A and B, and ask your Physician to complete Section C if:

- You are claiming for inpatient, emergency, or surgical claims, or claims involving complex treatments/tests, accidental injury, or major illness
- The diagnosis has not been provided on the documents from the doctor
- You have not been advised you may require surgery, hospitalisation, or specialised testing for this disability

SECTION A

Policy/Member Information

Patient Name:	Policyholder Name:
Policy Number:	Member Number:

Contact Details (if different from policy)

Address:	
Telephone:	Email:

SECTION B (To be answered by member or parent if a minor)

If this claim pertains to illness:

When and how did this illness first occur?
When did you first consult a doctor about this problem or these symptoms? Please provide the doctor's name and contact information for previous consultations for this problem/symptoms.
Have you ever had a similar illness or symptoms? If yes, please give full details below:

If this claim pertains to an accident:

Date, time and exact place of accident:
Briefly describe how this accident occurred:
Was a third party involved? If yes, please describe their part in this accident, and state whether reimbursement/compensation will be provided.

Declaration

I hereby declare that all information provided on this form and the documents submitted herewith are true and correct to the best of my knowledge and belief. The amounts claimed are the actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source.

Authorisation for Release of Information

I authorise any doctor, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to the Insurer ("the Company") any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefore. If this claim relates to an accident, past or present, I also authorise any governmental body, agency, or other person or organisation who may have records pertaining to such accident to release such records or information. I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organisation(s) performing business or legal services in connection with my claim, save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Signature of Member (Parent if minor)

Date (DDMMYY)

SECTION C (To be answered by the Attending Physician, at claimant's own expense)

Patient Name:		*Policy/Member Number:*	

1. State briefly the nature of the illness or injury.
2. When did the symptoms first arise?
3. On what date did the patient first consult you for this condition?
4. Has this patient ever suffered from this condition before? ☐ *No* ☐ *Yes (please explain)*
5. Has the patient ever had any similar condition or related symptoms before this incident? ☐ *No* ☐ *Yes (please explain)*
6. Is this related to any accident or injury, or in any way connected with the patient's employment or job duties? ☐ *No* ☐ *Yes (please explain)*
7. Please provide full reports including but not limited to past medical history, referral letters, investigative procedures, and treatments:
8. (Claims for surgery) In addition to information in (7) above, please provide name and date of surgical procedure(s), operation notes, pathology report, and discharge summary.
9. (Claims involving pregnancy) Please state approximate commencement date of pregnancy or date of Last Menstrual Period: *I__I__I/I__I__I/I__I__I__I__I (DD/MM/YYYY)*

Attending Physician Name:		
Address:		
City:	*Postal Code:*	*Country:*
Tel:	*Fax:*	*Email:*

Physician's Signature *Date* *Official Stamp*

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