William Russell
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Global Health Plans

General Claim Form

Please complete this form in **BLOCK CAPITALS** using black ink, following the instructions below.

If the total amount you are claiming is less than US $500, you only need to complete **Section A** of this form. Please return the form to us by email, fax or post, attaching a copy of the invoice breakdown and the receipts as proof of payment.

If the total amount you are claiming is greater than US $500, you need to complete **Section A** and your **physician** needs to complete **Section B**. You must return the form and the original receipts to us by post.

You can find our contact details at the end of this form.

A SECTION A

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

Your personal details

Full name: ..... Plan number: .....

Address: .....

.....

..... Date of birth: .....

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

Please state the name and address of your regular physician.

Name of physician: .....

Address: .....

.....

.....

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

Email address: .....

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

Please attach separately the original and fully itemised bills.

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

How you wish to be reimbursed

☐ **Payment to your VISA credit or debit card**

Please note we can only make payment to a visa card. Settlement can be provided in US Dollars, GBP Sterling or Euros. If we have previously reimbursed a claim, you will need to complete again the details below, because, for security purposes, we do not store card information.

Card number: ……

Start date: …… …… Expiry date: …… ……

Name as it appears on your card: …… ……

Address to which your card is registered: …… ……

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☐ **Payment to your bank account**

If you have previously submitted a claim, and you wish to receive reimbursement to the same bank account as before, you do not need to complete the fields below.

Currency in which you would like to be reimbursed: ……

Name of bank: ……Account name: ……

Account numer: …… IBAN: ……

Sort code: …… Swift code: ……

BIC number: ……Full address of bank: ……

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Consent for release of medical information

In order to consider your claim, we will need to obtain copies of your medical reports and/or records from your physician. We can only obtain these with your consent and therefore need you to complete the declaration below.

Under the Access to Medical Reports Act 1988, you have certain rights in relation to reports and/or records requested by us which have been prepared by your physician, and these are summarised as follows:

1) You can indicate in the declaration below that you do not wish to see the reports and/or records before they are sent to us. The physician that has treated you, or is planning to treat you, will then send the reports and/or records directly to us.

2) You can indicate in the declaration below that you wish to see the reports and/or records before they are sent to us. When we request your reports and/or records from your physician, we will inform you. You will then have 21 days to contact your physician to view your reports and/or records, and to give consent to your physician to send the reports and/or records to us. Should there be any charge for providing you with a copy of the reports and/or records, it will be your responsibility to pay the charge. If you do not contact your physician within 21 days, the reports and/or records will be sent to us directly. You can ask your physician if he/she will amend any part of the reports and/or records which you consider to be incorrect or misleading. If your physician is not in agreement, you may attach your comments before the reports and/or records are sent to us.

3) You can withhold your consent. However, if you withhold your consent we will be unable to proceed with your claim.

Your physician is entitled to withhold from you some or all of the information contained in the reports and/or records if: (a) he/she considers that it may be harmful to you; (b) it would indicate his/her intentions in respect of you; or (c) it would reveal the identity of another person without their consent.

Your personal information will be processed by William Russell Limited in accordance with the Data Protection Act 1998.

Declaration and authorisation

I hereby confirm that I have been informed of and understand my rights under the Access to Medical Reports Act 1988. I hereby authorise any physician, doctor of medicine, hospital or other medical professional who has attended or examined me, to furnish to William Russell Limited or to its authorised representative any and all information with respect to illness or injury, medical history, consultation, prescriptions, medical investigations or treatment, and copies of all hospital reports and/or medical records.

☐ I wish to see a copy of the reports and/or records before they are sent to William Russell Limited

☐ I do not wish to see a copy of the reports and/or records before they are sent to William Russell Limited

I consent to use of the information by William Russell Limited for the purpose of data processing, electronic or otherwise; for assessing my claim(s); for medical underwriting; and for disclosure to other medical professionals involved in my treatment or care, to William Russell Limited's medical officers and emergency assistance service providers (including those based outside the European Union), to my medical insurers and reinsurers, and to the plan holder (if other than myself).

Do you have any other insurance cover?

☐ No, I have no other health insurance cover. ☐ Yes, I have cover with: .....

I hereby give William Russell Limited the 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.

Name of claimant*: .....

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.

B SECTION B

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

Patient's details

Full name: .....

Date of birth: ..... Nationality: ..... Gender: ☐ Male ☐ Female

Was the patient referred to you? ☐ Yes ☐ No

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

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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: .....

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

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Your diagnosis

What is your clinical diagnosis? .....

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

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Your treatment plan

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

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Medical information

Please answer all of the following questions:

1) 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: .....

.....

.....

2) Does the patient have a history of any of the following:

High blood pressure, high cholesterol, heart or circulatory disorders?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Asthma, respiratory or allergic conditions?	☐ Yes	☐ No
Spine, bone, joint or muscle conditions?	☐ Yes	☐ No
Cancer?	☐ Yes	☐ No
Psychiatric, psychological or mental disorders?	☐ Yes	☐ No
Any other disease or injury requiring in-patient treatment?	☐ Yes	☐ No

If YES, please provide full details, including date of onset and treatment received:

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Declaration by physician

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

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

Print your name and address: .....

.....

.....

Email address: ....

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

Qualifications: .....

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP BELOW:

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E: claims@william-russell.com