GlobalHealth®

Claim Form

Complete Section A, B and sign the Declaration if:

- You are claiming only for outpatient doctor visits, medications, and general laboratory tests, and
- 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, hospitalization, or specialized testing for this disability.

Complete Sections A and B and have your physician fill out Section C if:

- You are claiming for inpatient, emergency, or surgical claims, or claims involving complex treatments/tests, accidental injury, or major illness.

Section A

Policy/Member Information

Name of Patient:

Policyholder name:

Policy Number:

Member Number:

Contact Details (if different from policy)

Address:

Country:

Telephone (H)

Telephone (O)

Facsimile:

☐ Send settlement to this address

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?

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 his/her part in this accident, and state whether reimbursement or other compensation will be provided.

Declaration

I hereby declare that all information provided on this form and the documents submitted herewith is 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.

Authorization for Release of Information

I authorize 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 therefor. If this claim relates to an accident, past or present, I also authorize any governmental body, agency, or other person or organization 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 organization(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

Section C

To be answered by Attending Physician

1. State briefly nature of 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 the patient ever suffered from this condition before?
   ☐ No ☐ Yes (explain)
5. Has the patient ever had any similar condition or related symptoms before this incident?
   ☐ No ☐ Yes (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 (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 LMP:

Name & Address of Attending Physician:

Physician's Signature & Date:

Important:

- Have you completed Section A?
- Have you signed the Declaration and Authorization for Release of Information?
- Have you enclosed all original bills, statements, receipts, and other documents?
- If required, have you completed Section B?
- If you have completed Section B, has your physician completed and signed Section C?

Please send completed form and all original bills, statements, receipts, and other documents to:

GlobalHealth Asia Limited
Suite 1401-3, Chinachem Hollywood Centre
1–13 Hollywood Road, Hong Kong
Telephone (852) 2526-0505
Facsimile (852) 2526-0769

Please contact us if you have questions how to claim.