This form is made up of five short sections:

A Policyholder's and patient's details
B Details of any secondary insurance
C Medical details
D Payment options
E Declaration

Please complete form in full. Failure to do so may delay the payment of your claim. Proof of claim must be submitted within 180 days of accident or illness. A separate claim form should be used for each patient and each medical condition.

All claims should be completed in English. If submitting invoices in other languages, please provide a brief description.

FORM CHECKLIST

- ✓ Only complete this form if you are claiming on your health insurance policy. If you require a different form please call **+44 333 405 3003**
- ✓ Please check you have signed and dated the form on the last page.
- Once completed please email your form with itemised bills and receipts to:

  assist@lamphealthcare.cn

  Alternatively, post it to: **Chester House, Harlands Road, Haywards Heath, West Sussex, United Kingdom RH16 1LR**

SECTION A POLICYHOLDER'S AND PATIENT'S DETAILS

Membership number Find this on your membership certificate or on your ID card.	
Policyholder's name	
Policyholder's date of birth (DD/MM/YYYY)	
Policyholder's email address	
Patient's relationship to the policyholder	☐ I am the policyholder (Please go to section B) ☐ Spouse ☐ Child ☐ Other
Patient's name	
Patient's date of birth (DD/MM/YYYY)	
Patient's gender	☐ Male ☐ Female
Patient's email address	

SECTION B DETAILS OF ANY SECONDARY INSURANCE

Policy number	
Policyholder's name	
Patient's name	
Insurance company	

SECTION C MEDICAL DETAILS

All sections must be completed by either the provider or member.
For foreign language claims, please complete this section in English.

MEDICAL PRACTITIONER'S DETAILS

Name

Address

PATIENT'S DIAGNOSIS AND TREATMENT

Diagnosis/symptoms

Onset date when symptoms first noticed by patient (DD/MM/YYYY)

When did the patient first see a doctor? (DD/MM/YYYY)

Details of treatment

Details of operation

Details of medication

HOSPITAL DETAILS

Hospital admission date (DD/MM/YYYY)

Discharge date (DD/MM/YYYY)

Hospital name

Hospital address

Telephone

Email

CHARGES

Charges and currency

SECTION D PAYMENT OPTIONS

REIMBURSEMENT: payments are made in USD dollars unless another currency is requested below. All payments are subject to USD exchange rate on the day of payment. Your bank or other intermediary banks may apply a fee for the receipt of a wire transfer and these fees are not reimbursable under this plan. I hereby authorise that if payment is going to the hospital or physician as indicated on receipts, I understand that I am financially responsible for charges not covered by the policy.

Who are we reimbursing? ☐ Doctor/provider ☐ Policyholder ☐ Patient ☐ Group (if on a company plan)

PAYMENT BY ELECTRONIC FUNDS TRANSFER TO A BANK ACCOUNT

Bank name	
SWIFT/BIC code*	
Sort code	
Account number	
IBAN number	
Account name/payee	
Currency of transfer	
Bank address	
Postcode/ZIP code	
Country	

*In order to process your payment as quickly and securely as possible, please ensure that you provide both the IBAN and SWIFT code of your bank branch. Your bank will be able to provide you with this information if necessary.

We recommend that bank transfers are made in the currency of your bank account. If you have asked us to pay the provider, and an annual deductible applies to your cover, the deductible will be collected using your direct debit or credit card.

SECTION E DECLARATION

Data protection and release of medical records

References to information includes personal information given by you to us, in your claim or pre-authorisation form and/or supporting documents/information we collect in connection with products or services we provide.

Personal information may be used for insurance administration (e.g. underwriting, claims handling, fraud prevention). We may use third parties to process data on our behalf. Such processing is subject to contractual restrictions regarding confidentiality and security in line with data protection obligations.

We need to collect sensitive data relating to you (e.g. health details), to assess insurance terms and/or administer claims.

We may share your information with our agents, other insurers and their agents, service providers, any intermediary acting on your behalf or governing/regulatory bodies (of which we are a member or by which we are governed). In certain circumstances, we may use private investigators to investigate a claim you have submitted.

We are obliged to retain your records for six years from the date the insurance relationship ends. We will not retain your data for longer than necessary and will hold it only for the purposes for which it was obtained.

By signing this form you confirm that you have the authority to act on behalf of your dependents in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependents.

You have the right to request and receive a copy of your personal data held by us. If you wish to do this, please write to us at the address provided on this form or via:

member-care@integraglobal.com

Calls to our helpline may be be recorded and monitored for training, quality and regulatory purposes.

I certify that to the best of my knowledge, this claim form does not contain any false, misleading or incomplete information. I understand that in the event that this claim is found to be fraudulent, in whole or in part, the contract will be cancelled from the date of discovery of the fraudulent event and I may be liable to prosecution.

I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I authorise my medical practitioner, health professional or other relevant medical establishment to provide relevant medical information relating to me, if requested by us, our medical advisers, appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply.

If a minor was treated, a parent or guardian should sign this section.

PRIMARY INSURED SIGNATURE	DATE (DD/MM/YYYY)

Islamic Arab Insurance Company PSC ("SALAMA")
Phone: +971 4 404 0117
4th floor, Spectrum Building, Oud Metha, Sheikh Rashid Road, PO Box 10214, Dubai, United Arab Emirates

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