Gulf Insurance &Reinsurance | gig GULF INSURANCE GROUP

Medical Claim Form

To be completed by Employee / Patient

POLICY NO. _____ POLICYHOLDER NAME: _____

Principal's Name : _____

Patient's Name : _____ Membership No. : _____

Please tick relation to Employee / principal: Wife ☐ Husband ☐ Child ☐

Is the cost of this treatment also covered by any other Insurer? YES ☐ NO ☐

Was the treatment as the result of an accident? YES ☐ NO ☐

If the answer to either question is YES, please give full details.

TOTAL CLAIM AMOUNT ☐ CURRENCY ☐

I hereby claim for costs of treatment and declare that, to the best of my knowledge and belief, all information given in support of this claim is true and complete.

Group Member's Signature : _____ **Date :** _____

Diagnostics : _____

_____

_____

Investigations required : _____

_____

If Pregnant, Expected Date of Delivery : _____

Doctor / Specialist's Signature & Stamp _____ **Date:** _____

Notes:

1.- All original prescriptions filled and signed by the treating physicians (photocopies of supporting documents are not acceptab

2.- Photocopy of the insurnace card is required.

3.- Claims have to be submitted no later than 60 days of the start of covered medical treatment.

4.- Claims will be reimbursed within 21 days of Company's receiving full documents.

3.- Amounts not supported by orginal documents will not be considered as part of your claim.