

Sun Alliance Insurance (China) Limited

INTERGLOBAL HEALTHCARE PLANS

Medical Claim Form

For medical treatment reimbursements

Please complete clearly in block capitals.

Please remember these important points about filling in your claim form:

- Assessment of your claims may be delayed if you and your medical or dental practitioner do not fill in all the necessary sections of this form.
- Return this form to us within six (6) months of the first treatment date.
- Always send us the original invoices with this form. Photocopies, receipts and credit card statements will not be accepted.
- Make sure that you fill in sections A to G and that all doctors who have treated you fill in section H (or section I for dental treatment).

A – Patient details *If the patient is a dependant under the age of 18, the main member must fill in section A to G for the patient.*

Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other:		
Family Name:		First Name(s):
Date of Birth (dd/mm/yy):	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Group name (if applicable):		
Member number:		Plan number:
Correspondence address:		
Postal code:	Country:	
E-mail:	Telephone:	Fax:
Symptoms/condition needing treatment:		

B – Main member details

Family name:	First name(s):
Member number:	Plan number:

C – Further information

Does the patient have another insurance policy that covers medical costs? Yes No

If yes, please give details on a separate sheet.

D – Hospital cash benefit

Are you claiming hospital cash benefit? Yes No

If yes:

- Please make sure that your attending medical practitioner, specialist or consultant gives the dates of admission and discharge in section H
- Please send us the original admission and discharge form from the hospital where the treatment was given

E – Payment details

Have you personally had to pay costs for the treatment that you are claiming for? Yes No

If yes, and you are personally seeking reimbursement, please complete details below for bank transfer payments:

1. Bank transfer; Please fill in this information for bank transfer payments:

Name of your bank:	Account number:
Name of account holder:	Address of your bank:
Bank sort code:	Swift Code/Routing Code:
Currency of bank account:	

Please note:

1. If you receive a claim payment and then decide that you would like the payment in a different currency or payment method from the one that you choose on this form, we reserve the right to pass on to you any payment charges incurred by us for canceling the original payment or raising a new one.
2. We will not be responsible for any payment shortfall due to exchange rate fluctuations.

F – Claim details

Date of treatment	Invoice date	Invoice reference	Amount (including currency)

G – Signed declaration

I declare that all the details provided on this claim form represent a true and accurate statement and that I have not omitted any details pertinent to the circumstances of this claim. I understand that in the event that this claim is found to be fraudulent in whole or in part, I am committing a criminal offence and that this will invalidate the plan and render me liable to prosecution under P.R.C Law. In respect of any medical claim I hereby authorise any Medical Practitioner, Specialist, Consultant, Therapist or other relevant establishment who has previously attended me/or is currently attending me/patient, to provide any details that may be requested by Sun Alliance Insurance (China) Limited (RSA).

I confirm and agree that any personal information collected or held by RSA, whether contained on this form or otherwise obtained may be used by RSA, or disclosed to or transferred to any organisation for the purpose of i) assessing this claim and providing on-going insurance cover, customer service and the processing of subsequent claims, ii) processing and effecting payments, iii) providing marketing communications in respect of RSA, its related products and services and those of its associated companies.

Patient's/member's signature: _____ Date (dd/mm/yy): _____

H – Medical information (except dental) *This section must be filled by the Medical practitioner/Specialist/Consultant/Therapist.*

Note to the Medical Practitioner/Specialist/Consultant/Therapist: Please give this form back to the patient after you have filled it in. For dental treatment, please use section I (over the page).

I. Contact details

Name of medical practitioner/specialist/consultant/therapist:	
Qualifications:	
Telephone Number:	Fax Number:

2. Referrals

a) Was the patient referred to you? Yes No

Name of referring practitioner:	Qualifications:
Address:	
Telephone Number:	Fax Number:

b) Have you referred the patient? Yes No

Name of specialist/consultant to whom you referred the patient:	
Qualifications:	Date of referral (dd/mm/yy):

3. Symptoms

a) Has the patient suffered from the same or similar symptoms before? Yes No

If yes, please give details:

b) On what date did the patient first noticed these symptoms (dd/mm/yy)?
c) On what date did the patient first present symptoms to you (dd/mm/yy)?
d) Please give full details of the symptoms needing treatment:

4. Investigation requested

Please give details:

5. Diagnosis

Diagnosis of medical condition, if known:

ICD10 code:

Treatment proposed:

Is a follow-up visit needed? Yes No

If yes, when(dd/mm/yy)?

6. Type of condition

In your opinion, is this condition: Acute? Chronic? Acute episode of a chronic condition?

7. Type of complementary treatment recommended (if relevant)

a) Physiotherapy

Number of sessions needed:

b) Osteopathic treatment

Number of sessions needed:

c) Chiropractic treatment

Number of sessions needed:

d) Homeopathic treatment

Number of sessions needed:

e) Acupuncture

Number of sessions needed:

f) Chinese medicine

Number of sessions needed:

8. Hospital admission

Has the patient been admitted to hospital for this condition? Yes No

If yes, please give admission date (dd/mm/yy):

And discharge date (dd/mm/yy):

9. Cosmetic treatment

In your opinion, is the treatment for cosmetic reasons? Yes No

10. Declaration

I declare that to the best of my knowledge and belief the statements made on this claim form are full, true and complete.

Medical Practitioner's/Specialist's/Consultant's/Therapist's signature: _____

Date (dd/mm/yy): _____

I – Dental treatment *This section must be filled in by the dental practitioner.*

1. Contact details

Name of dental practitioner:

Qualifications:

Telephone Number:

Fax Number:

2. Symptoms

a) Was the patient suffering from dental pain when they first visited you? Yes No

b) Has the patient suffered from the same or similar symptoms before? Yes No

if yes, please give dates:

c) On what date did the patient first notice these symptoms (dd/mm/yy)?

d) On what date did the patient first present these symptoms to you (dd/mm/yy)?

e) Please give full details of the symptoms needing treatment:

3. Treatment

a) In your opinion, was the dental treatment: Routine? Emergency?

b) Please fill in the dental chart by using the abbreviations below:

Dental chart																		
	Right								Left									
Treatment																		Treatment
Finding																		Finding
Upper jaw	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper jaw	
Lower jaw	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower jaw	
Finding																	Finding	
Treatment																	Treatment	

Finding:

b = bridge

c = crown

ca/da/dn = caries/decay/dental necrosis

cl = calculus

g = gap closure

gb = gingival bleeding

gi = gingivitis

gs = gingival swelling

i = implant

in = inlay

m = missing tooth

p = periodontitis

pu/od = pulpitis or odontitis

Treatment:

AF = amalgam filling

CF = composite filling

D = denture

E = extraction

I = implant

IN = inlay

M = metal ceramic crown

NB = new bridge

NC = new crown

O = orthodontics

ON = onlay

OR = oral radiograph

PR = panoramic radiograph

RB = replacement bridge

RC = replacement crown

RCT = root canal treatment

S&P = scale and polish

If the treatment was NC or RC, was a precious or semi-precious metal used? Yes No If yes, what?

If the treatment was IN or ON, was a precious or semi-precious metal used? Yes No If yes, what?

4. Declaration

I declare that to the best of my knowledge and belief the statements made on this claim form are full, true and complete.

Dental practitioner's signature: _____ Date (dd/mm/yy): _____

No claims discount

Applies to individual and family plans only and not Group Plans

Please note: By making this claim, you will affect your no claims discount.

Excess

If you have an excess on your plan, this will be deducted from any reimbursement.

Checklist

Have you enclosed:

- A fully completed claim form with signed and dated declaration
- Original itemized invoices (copies will not be accepted)
- Original admission and discharge form if claiming Hospital Cash Benefit

Send your claim to:

Medical Claim Team, Sun Alliance Insurance (China) Limited

7th Floor, AZIA Center, 1233 Lujiazui Ring Road, Pudong New Area, Shanghai, 200120

Hotline +86 800 820 5918, Tel +86 (0)21 6888 1999 x 268, Fax +86 (0)21 6888 5553, Email: customercare@cn.rsagroup.com