WILLIAM RUSSELL
Peace of mind wherever you are

Global Health plan
Claim form

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Global**Health**

PLEASE READ THESE INSTRUCTIONS CAREFULLY

It is important that you give a clear answer to each question.
Please ensure that your physician gives complete answers to all the relevant questions overleaf and signs.
Claims must be submitted within 6 months of the first consultation. Failure to submit your claim within this 6 month period will invalidate your claim.

A. YOUR PERSONAL DETAILS

1. **Full name of Global Health policy holder:**
2. **Full name of patient:** **Date of birth (D/M/Y):**
3. **Policy number:** **Sex: [ ] Male [ ] Female** **Title: Mr/Mrs/Miss/Ms/Dr**
4. **Full mailing address:**
5. **E-mail address:** **Tel:**

B. PHYSICIAN DETAILS

1. **Name of your physician:**
2. **Address:**
3. **E-mail address:** **Tel:**

C. DETAILS OF YOUR CLAIM

1. **Please give details of your symptoms (attach as necessary):**
2. **Please state the date on which the symptoms first occurred (D/M/Y):**
3. **If you are claiming for an accident please describe your injuries and the date the accident occurred (D/M/Y):**

D. OTHER INSURANCE

1. **Do you have any other health or related insurance policies:** **[ ] Yes** **[ ] No**
2. **If you do have other health insurance policies please state the insurer name and your policy number . Please attached policy schedule.**

Name: ______________________________ **Policy No.:__________________________________**

E. PAYMENT METHOD

Our Preferred method of settlement is direct to your back account. If you would like us to make settlement in this way please complete your bank details here:

Account name:		Account number:	
Bank name:		Sort or Swift Code:	
Bank Address			
Currency of Settlement:			

If you would prefer settlement by cheque or draft, please give your instructions here

Method of settlement	
Currency*:	
Payee:	
Other Instructions:	

*Unless we are advised otherwise, settlement of your claim will be made in the currency of your policy.

F. DECLARATION

I hereby declare that the above information is true and complete.
I further authorise any hospital, physician , insurance company or organisation that has any records or knowledge of me or my health to provide such information to William Russell Limited or William Russell [Far East] Limited and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A Photostat copy of this authorisation shall be considered as effective and valid as the original.
I understand that if I and/or the patient fail to provide any information requested in this claim form it will result in William Russell being unable to accept or process this claim.

______________________________ ______________________________
Signature of Policyholder **Date**

TO BE SIGNED BY TREATING DOCTOR 由主診醫生填寫和簽署

A. Patient Details 病人資料

Name of patient 病人姓名:

Date of birth 出生日期:

B. CLINICAL HISTORY 診治病歷

1. **Please state the date on which the patient FIRST contacted you for this condition (D/M/Y):**
   請提供病人因這病徵首次看診的日期 (日/月/年):
2. **What were the patient's symptoms?** 病人有甚麼病徵?
3. **How long had the patient have been experiencing these symptoms before the first consultation?**
   在病人首次看診前, 這個病徵出現了多久?
4. **What is your clinical diagnosis?** 你有甚麼診治結論?
5. **On which date did you make this diagnosis (D/M/Y)?** 你在何時得到這診治結論(日/月/年)?

C. TREATMENT HISTORY 治療經過

1. **Please state diagnostic tests performed and your reason for the tests?** 請陳述診斷測試及原因:

Date(s) (D/M/Y) 日期(日/月/年)	Tests performed 診斷測試	Reason for tests 測試原因
_______	________________________	____
_______	________________________	____

Please attach additional Information 請提供附加資料

2. **What treatment has been provided and when?** 請陳述所提供的治療及日期

Date(s) 日期 (D/M/Y) (日/月/年)	Details of treatment provided 治療詳情
__________	____
__________	____

D. YOUR PROFESSIONAL COMMENT 專業意見

1. **For how long have you known this patient?** 你認識病人有多久?
2. **In your opinion, how long would the symptoms apparent before the first consultation?**
   在病人首次看診前, 你認爲這個病徵出現了多久?
3. **In your opinion is the patient's condition a recurrence of an existing disease?**
   你認爲病人是次病徵是否爲舊病復發? [ ] **Yes** 是 [ ] **No** 否
   If YES, when was the first episode of the existing disease? 若是, 何時第一次發病?
4. **Are you the patient's usual physician?** 你是否病人的家庭醫生? [ ] **Yes** 是 [ ] **No** 否
   If No, does the patient have any other usual/family doctor? If yes, please give names and telephone number:-
   若否, 病人有否其他家庭醫生? 若有, 請提供姓名及電話號碼:-
5. **Has the patient been referred to you by another doctor?** 病人是否經其他醫生轉介? [ ] **Yes** 是 [ ] **No** 否
   If Yes, please give name and telephone number of the referring doctor:-
   若是, 請提供轉介醫生的姓名及電話號碼:-

E. SURGEON/ATTENDING PHYSICIAN STAMP AND SIGNATURE 外科/主診醫生印章及簽名

Name of Doctor:
醫生姓名:

Telephone:
電話:

E-mail address:
電郵地址:

Address:
地址:

____

Date (D/M/Y)
日期(日/月/年)

____

Signature and chop of surgeon/attending physician or authorised signature and chop of hospital
外科/主診/醫生印章及簽名 或 醫院授權印章及簽名