SUKOON™
INSURANCE

HEALTHCARE INSURANCE

REIMBURSEMENT CLAIM FORM

Receive your claim payment faster by updating your bank details on the mySukoon app or on https://medical.sukoon.com/

1. Claimant Details

1. Claimant Name	Suhaan Sharma
2. Card Number	
3. Mobile Number	0 5 0 3 2 0 9 8 3 0
4. Email Address	

2. Principal Member Bank Details (in case not provided already or needs to be updated)

1. Account Name	
2. Bank A/C #	
3. Bank Name	
4. Branch	
5. IBAN (23 digits)*	

*Update IBAN on the mySukoon portal or the mySukoon app. For policies where payment is set to group, the IBAN must be provided by your company on the company letterhead along with the HR/Accounts email ID.

3. Claim Details

1. Is the claim in UAE?	☑ Yes ☐ No	If No, Precise Country: Dubai
2. Name of Hospital/Dr.	Dentistree Dental Clinic	
3. Date of Treatment	01/03/24	
4. Number of Invoices	1	
5. Total Amount Claimed	500	
6. Currency	AED	

For breakdown of Total Amount Claimed, use attached summary table cover sheet to tabulate entries in chronological order.

DENTISTREE DENTAL CLINIC

4. Medical Details – To be Completed by the Treating Doctor

1. Is it work related?	☐ Yes ☐ No	If Yes, Specify:
2. Treatment Type	☐ In-Patient ☐ Out-Patient ☐ Day Care	
3. Chief Complaint	Bleeding gums while brushing	
4. Diagnosis	K05.10 - Acute gingivitis, plaque induced	
5. Treatment Details	Scale and polish	

I, the undersigned treating doctor, hereby declare I have attended to this patient and the particulars provided are correct and accurate to the best of my knowledge.

Doctor Name & Stamp: Dr. Rutul Desai, General Dentist, DHA-4433932-001, DENTISTREE DENTAL CLINIC

Signature: R. K. Desai

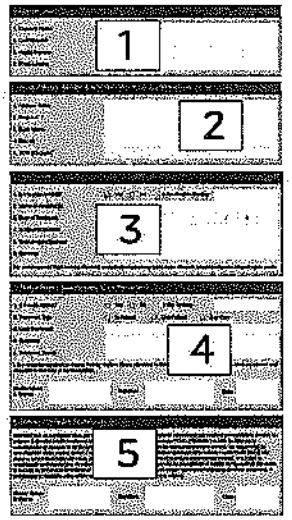
Date: 9/3/24.

5. Claimant's Declaration & Authorization

I confirm that all particulars filled are true, accurate and complete. I hereby authorize (i) the medical provider/other entities to provide & discuss health/treatment details with Oman Insurance Company P.S.C. (hereinafter referred to as "Sukoon") and/or its third party administrator (ii) Sukoon to (a) disclose my personal/claim information for claim processing or as may be required (b) to use alternate claim payout option if required (iii) contact me for claim/other products information. I understand that (i) any person, who intentionally conceals, makes false or misleading statement to obtain claim reimbursement, is subject to penalization and legal action (ii) acceptance of claim form does not constitute acceptance of liability by Sukoon (iii) my claim is subject to terms and conditions of my policy. This authorization shall remain valid notwithstanding death or incapacity. A photocopy or facsimile copy of this authorization shall be as valid as the original.

Claimant Name	Signature	Date

HOW TO COMPLETE THE FORM



One Claim Form per person, family members must apply individually.For the required supporting documentation, use the attached Summary Table as cover sheet. Before you submit, check your Table of Benefits in your policy document for exclusions to avoid rejections.

Please submit the form within 120 days of treatment to ensure timely processing. Both you and the attending doctor must fill in the claim form for each individual visit or course of treatment. Please look at the below definitions to understand who is Principal member, Dependent and Claimant.

Principal Member is the **insured employee** under the policy.

Dependent refers to Principal Member's spouse or children.

Claimant is the person undertaking the treatment.

Principal Member: Please fill section 2

- To help us transfer the settled claim amount to you or your dependent's bank account, please update the IBAN of the account on the mySukoon portal or the mySukoon app. For policies where payment is set to group, the IBAN must be provided by your company on the company letterhead along with the HR/Accounts email ID. In case the IBAN is not provided, we will issue a cheque which will take 10 additional days.

Claimant: Please fill section 1, 3 & 5

- Fill in your name and card number. Give us your contact details so we can keep you informed on the progress of your claim by SMS or e-mail.
- Include the breakdown of expenses that need reimbursement. Complete the summary table on the next page giving the full required details. Each invoice detail should be on a separate line.
- Read the Declaration section carefully and remember to sign and date the form.

Doctor: Please fill section 4

- Please ensure that the doctor completes each question of the Medical section in full and then signs and stamps it.

Claim Submission

Online	Physical Submission	Courier
Submit your claim online through the mySukoon portal or mySukoon app. For claims above AED 5,000 you will need to submit the original documents.	Deposit your claim at: Your HR department, broker or at one of our branches.	Send your claim by mail to:Medical Claims Department, Sukoon , Omar Bin Al Khattab Street, Next to Al Ghurair Mall, Deira, P.O. Box 5209 Dubai, UAE Tel: +971 4 230 2700

Claim Processing

We aim to pay your complete eligible claims within 10 calendar days. Please remember that we will reimburse you as per the customary prices in our network. This means that if your doctor charges a general consultation fee of AED 400, when the average consultation fee is AED 250 in your applicable network, we will reimburse you on the basis of AED 250. Moreover, if mentioned in your table of benefits, we might apply a co-insurance over and above your network deductible. If it does, we usually apply 20% co-insurance. In the above example, if your network deductible is AED 50, we will apply 20% co-insurance on AED 200, and reimburse AED 160.

SUMMARY TABLE OF INVOICES

REIMBURSEMENT CLAIM FORM ATTACHMENT

Mark the sequence number of the corresponding invoice.

Sequence Number	Service Date	Provider Name	Service Description	Invoice Ref. Number	Claimed Amount	Currency
1	01-03-24	Dentistree Dental Clinic	Scale and polish	INV-1000682	AED	500/-

In case you have more invoices to send, please photocopy this sheet.

Checklist - Before you submit, please check that you have included all of the following as applicable:	✓
1. Completed, stamped and signed Reimbursement Claim Form	
2. Original invoices/bills showing payments confirmation	
3. Medical and/or Lab test reports	
4. All claims submitted must be in original & translated to either English or Arabic for the settlement	
5. Healthcare Insurance card copy of the claimant	
6. Summary Table of Invoices (above) completed	
7. You have retained a copy of the Form, Summary Table and original invoices and report for your reference	

Claimant Name & Signature

Name _____ Signature _____ Date _____

If you have any enquiries, contact us on:	**800 SUKOON (785666)** UAE Toll Free 8 am till 8 pm Monday to Friday, 8 am till 5 pm on Saturday Fax: +971 (0) 4 238 4769 weserve@sukoon.com