



Softlogic Life Insurance PLC.,
 283, R A De Mel Mawatha,
 Colombo 03, Sri Lanka.
 Registration No. PQ 31
 Tel: +94(11)2315555
 Fax: +94(11)2372941
 E-Mail: info@softlogiclife.lk
 Web: www.softlogiclife.lk

CLAIM FORM

The insured member is required to complete the following claim form and attach all the original medical bills and supporting documentation when filing the claim. A separate claim form must be completed for each medical condition, each currency and each member. All sections must be completed.

SECTION A: PATIENT DETAILS TO BE COMPLETED BY INSURED MEMBER

Name of Main Applicant:	Membership No.:	Date of Birth:	Gender:
<u>MOHAMMED RIZVI</u>	_____	_____	_____
Name of Patient (If other than the main Applicant):	Membership No.:	Date of Birth:	Gender:
_____	_____	_____	_____
Present Contact Address:			

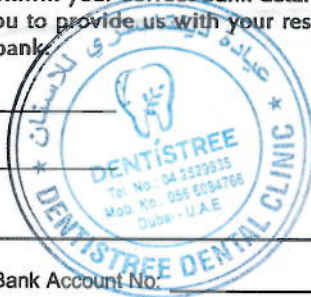
Telephone number:		Email Address for Remittance Advice:	
_____		_____	

SECTION B: SETTLEMENT DETAILS

We settle all eligible claims by bank transfer (EFT), therefore it is important that you confirm your correct bank details every time you make a claim. Due to new regulation in the banking sector, we also need you to provide us with your residential address (registered to your bank account) so that we can pay claims directly into your bank.

Total amount claimed (including currency): AED 2,1KSD

Currency of Reimbursement: AED



Bank Transfer – All fields in the box below are MANDATORY:

Name of Main Bank Account Holder:	Beneficiary Bank Account No.:
Account Holder address (residential address registered with the bank):	
Name of Bank, Branch and Location:	
Swift Code/BIC:	Sort Code (for UK banks only):
IBAN number:	
PLEASE NOTE:	
<ul style="list-style-type: none"> It is important that you complete the bank details section in full. Any missing or unclear information may result in payments being delayed. Bank charges may apply when making bank transfers Payments are not made directly to any clinic, physician or medical provider 	

DECLARATION & AUTHORISATION

(This part must be signed by the patient or patient's parent/legal guardian if the patient is below 18 years of age)
 I hereby authorise any hospital, physician, person or organisation to disclose all information with respect to any illness, injury, medical history, consultations, 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 certify that the above statements and answers are true and complete to the best of my knowledge and belief.

Signature of Main Applicant	Date	Signature of Patient	Date
_____	_____	_____	_____

SECTION C: PATIENT DETAILS TO BE COMPLETED BY TREATING DOCTOR

Note: If there are multiple doctors, this section is to be completed by the last attending physician.

Patient's Name: _____

Membership number: _____

1. Diagnosis (BLOCK CAPITALS PLEASE) _____

K08.530 - FRACTURED DENTAL RESTORATIVE MATERIAL W/O
LOSS OF MATERIAL

K05.10 - CHRONIC GINGIVITIS, PLAQUE INDUCED.

2. What was the date of the first consultation? _____

3. Please specify onset date of symptoms: _____

4. Date Treatment received: _____

5. Nature of Treatment: CROWN ISW #2.
Oral prophylaxis.



6. Doctors previously consulted by the patient for the above condition:

Name:	Approximate Date:	Name of Clinic:	Address:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name of Physician/Surgeon and Qualifications: DR RUTUJ DESAI

Contact No.: _____

Signature of Physician/Surgeon: R. K. Desai

