softlogic LIFE

Softlogic Life Insurance PLC.,
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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:
MOHAMMED RIZVI			
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 2,150

Currency of Reimbursement: AED

DENTISTREE DENTAL CLINIC
DENTISTREE
Tel No.: 04 2529935
Mob No.: 055 6054766
Dubai - U.A.E

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:

- **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 IRW # 2.
Oral prophylaxis.

عيادة دينتاستري لطب الأسنان
DENTISTREE
Tel. No.: 04 3529935
Mob. No.: 056 6084768
Dubai - U.A.E
DENTISTREE DENTAL CLINIC

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 RUTUL DESAI.

Contact No.:

Signature of Physician/Surgeon: R. U. Desai Date:

Dr. Rutul Desai
General Dentist
DENTISTREE DHA-44339326-001
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