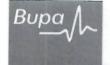
## BUPA GLOBAL CLAIM FORM



#### IMPORTANT INFORMATION

Return this form with original, or copy invoices via email, fax or post to; info@bupa-intl.com, Fax: +44 (0) 1273 820 517, or post: Bupa Global, Victory House, Trafalgar Place, Brighton, BN1 4FY, UK. Claims can also be submitted as eClaims via Membersworld.

Please ensure that all sections of the claim form are fully completed. Note that claims payment may be delayed if all sections of the claim form are not completed in full. The form should be returned to us within six months of the initial treatment date. Please write clearly in black ink and BLOCK CAPITALS.

Please complete a new / separate claim form for:

0	each	natient

o each in-patient / day-case stay

o each medical condition

each currency

If you have more invoices, you do not need to send a further claim form. Just send the invoices with a covering letter stating the condition and payment instructions. If the condition continues for more than six months, we may request a new claim form to be completed.

1 PATIENT'S DETAILS	(to be completed by the person unc	erdoina treatmenti
Patient membership number:	THE RESERVE OF THE PARTY OF THE	Group name (if applicable):
ВІ -		
Title: in R -		
First name: 11 well work		
Family name: VINAYAGAMO	athy	
Other names:		
Date of birth: 67-12 - 1949	Age last birthday:	
Correspondence address:		
Building:		
Street:		
Town / city:		
Area code:	PO Box:	
Region:		
Country:		
Email:		
Felephone:		
s this your permanent residency address?		Yes No
Do you want all future correspondence sent to this a	ddress?	Yes No
Oo you have a residence in the USA?		Yes O Po O' S STATE OF THE STAT
n which country did the treatment take place?	UAG	
Vhat is the currency of the invoice?	N-D	DENTISTREE *
What is the total amount of the claim?	1001	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

2 MEDICAL DETAILS collisect	ions must be completed by the dactor in overall ch	wige of the patient's treatment)
Medical Practitioner's details:		
Name: DL- DEATH NEW TO		
Address: ( 40 9 # 3 . In war pour vit	NE MISHE AL MINA NO	11, OUNTERN ALBERT LAND
Qualifications: General AFMIST		11, 100 100 11941 1 1140 1
	02.52	
Onset date when symptoms first noticed by patient:	101024	
When did the patient first see a doctor?	D D H 4 V V	
Details of treatment: Composit	e Restoratio	
	n,o,L)	
	D.O.L)	
Details of operation:		
Details of medication:		
		الماستري لد
		13 (m) 12 m
Dental treatment		DENTISTEE *
Annual check	Preventive	DENTISTREE Tel. No.: 04 2629935 Mob. Pio.: 056 6584766 Dubai - U.A.E
Major restorative	Orthodontics	O PREE DENTAL CO
Accident / emergency treatment	0	
Details of treatment: D239	2 -) #4 ( M,	a, L) > A ed 5001-
D 2 392	-) # S ( D, 0	(-) -) A ed 3001-
	D 2 4 Discharge date	
	DISCHAIGE CARE	101014
Name and address of admitting hospital:	Reference number:	
Name: 1 ENGLY MET NEWNAL CHMI		
Address: - Start 12 ALWE-		
Telephone: 64-2t79915		
Fax:		
Email: dennine dutal dinio 1 @	amail am	
Medical practitioner's / dental surgeon's signature		Date
( Pinter	Dr. Pearl Pinto	11-10-24
(/-	Dr. Pear Pilito	

2 Greinianana								
The hospital should complete this section if you have	e stayed in	hospita	l overnigt	t without	t charge, and y	our plan includ	es a Cash Benefit.	— <del>…</del> —~
l confirm that	************	*******	1					
The hospital needs to stamp this claim form here:	1717-131 <u>.</u>				-4	~~~~~~~~~~~		!
4 PAMMENTI DETIALLS								
	IMPOR	PANT I	NFORK)	ATION	7.00			
We can settle claims in over 80 c we will re	urrencies. In simburse you	a few ca u in the c	ises where currency of	we canno your subs	t settle in the cur criptions.	rrency requested	·	
Who would you like us to pay? (please tick one only)					The Paris State of the State of			
Doctor / hospital		0		member			0	
Please complete either Section A or Section B		<u> </u>	Group (I	on a com	pany plan)		O	]
Section A - Payment by cheque								:
In which currency would you like us to pay the cho	eque? (ple	ase tick	one only	7)		***************************************		
Currency of your invoices		0	Curren	cý of your	subscriptions		0	
Currency of your bank account		$\bigcirc$		:				
Please specify this:								
Cheques payable to members will be sent by post to the correspon	ndence addres	s provide	d on the fro	nt page.				
Section B - Payment by Electronic Funds Transfer	to a bank a	account	:					
Bank name:					111111111111111111111111111111111111111			1
SWIFT / BIC code &					TO THE TAXABLE PARTY.			
Sort code (UK only);						<del></del>		
Account numbers				Till	111111111111111111111111111111111111111			
IBAN:								
Account name / payee:								
Currency for the transfer:		<u>i</u> i						
Bank address:		<u>-</u> <u>-</u> 						
			<u> </u>					
Post/Zip code:		_!_						
Country.				<del>                                      </del>				

"In order to process your payment as quickly and securely as possible, we strongly recommend that you provide both your IBAN and the SWIFT code of your bank branch. Your bank will be able to provide you with this information if necessary.

We recommend that bank transfers are made in the currency of your bank account. If you have asked us to pay the provider, and an annual deductible applies to your cover, the deductible will be collected using your direct debit or credit card. We will instruct our bank to recharge the administration fee relating to the cost of making the electronic transfer to us, but we cannot guarantee that these charges will always be passed back for us to pay. In the event that your local bank makes a charge for an electronic transfer, we will aim to refund this charge. If we are unable to pay direct to a bank account, or no account details are provided, we will pay by cheque. We reserve the right to send any benefit due to an appropriate person – for example, the executors of the will pf someone who has died or the dependant on your membership who has paid the bill.

### 5 YOUR CONSENT TO OBTIAIN A MEDICAL REPORT

#### MORE AND THE RESTORAL

Please read this section carefully, as it sets out your rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (NI) Order 1991.

in order to process your claim, we may need to apply for a medical report from any doctor who has attended you. To apply, we need you to give your consent by signing the declaration below

You can choose from three courses of action:

I. You can give your consent without asking to see the doctor's report before it is sent to us. The report will then be sent directly to us by the doctor

You can give your consequ, but ask to see any report before it is sent to us, in which case you will Base 21 days, after we softly you that we have requested a report from the doctor, to contact, your doctor for doctor within 21 days, he will contact your forces from the doctor within 21 days, he will not a report of make a rangements to see the report. If you fall to contact, the doctor within 21 days, he will be entitled to send the report direct to us if howeveryour contact your discovery with a view to seeing the report, you must give the doctor written consent before he can release it to us. You may ask your doctor to change the report. If you tolk it is, indiseasing, if your doctor refuses, you can insist on actions your own comment to the report before it is sent to us. Should you give your consent to see it, you should you give your consent to so obtaining a report without indicating that you wish to see it, you can change your mind by contacting your doctor before the report is sent to us, in which case you will

have the opportunity to see the report and ask the doctor to change the report or add your comments before it is sent to us, or withtold your consent for its release.

3. You can withhold your consent but, if you do, please bear in mind that we may be unable to accept

Warether or not you indicate that you wish to see the report before it is sent, you have the right to ask your doctor to let you see a copy, provided that you ask turn within six months of the report having been supplied to us.

Your doctor is entitled to withhold some or all of the information consumed to the report if (a) he feels that it may be harmful to you or (b) it would indicate his intentions in lespect of you or (c) would reveal the identity of another person without their consent (other than that provided by a health professional in their professional in their professional repairty in relation to your care). Your doctor may also make a reasonable charge for his services.

The undersigned authorises and requests any trospital, specialist, physician or other health provider to furnish Bupa or its duly authorised agent agring on Bupa's behalf with such information as Bupa or that agent may seek from them in connection with any frealment or other services provided to me or my dependant for the nurpose of Bupa considering this claim.

I have been advised of my rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (NI) Order 1993.

Please indicate below if you wish to see a copy of the medical report before it is sent to Bupa: I do wish to see a copy of any medical report before it is sent to Bupa.

I do NOT wish to see a copy of any medical report before it is sent to Bupa.

#### Buna Global Data Protection Notice

Purpose: Personal data collected on you, and where appropriate, your family, will be used by Bupa. Global to process your claims, administer your policy and may be used to detect and prevent fraud or mproper claims

Confidentiality. The confidentiality of patient and member information is of paramount concern to the companies in the Bopa Groops To this end, Bupa fully complies with Data Protection Legislation and Medical Confidentiality Guidolines, Pupa sometimes uses third parties to process data on its behalf, Such processing, which may be undertaken outside the EEA; is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection

Medical Information: Medical information will be kept confidential, it will only be disclosed to those involved with your treatment or care, arounding your General Practitioner/Pigmary Health Physician, or to their agents, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents. Claims information may be discussed with the Bupa Global Acros (Advances Indoorgan). Agent/Adviser where you have requested the Adviser to assist you.

Member details: All memograhip documents and confirmation of now we have dealt with any claim you may make will be sent to the oringoal member

Telephone calls: in the interest of continuously improving our service to members, your call will be becomed and may be monitored

Research: Anonymised or aggregated data may be used by Bupa Global, or disclosed to others, for research or statistical purposes.

Fraud: Information may be disclosed to others with a view to preventing fraudulent or improper

Names and addresses: Bopa Global does not make the names and addresses of members or patients. aliable to other organisations

Keeping you informed: Bupa Global would, on accasion, like to keep you informed of Bupa products and services which it considers may be of interest to you.

Contact address: If you do not wish to receive information about Bupa's products and services, or have any other Data Protection queries please write to the Head of Information Governance, at Bupa House, 15-19 Bloomsbury Way London WCIA 28A or at DataProtection@Bupa.com

# THE ROUPARTY INSURING Are some of the costs recoverable from someone else (for example, state insurer or a person / organisation involved in an accident?): Yes Name' Address Email: Telephone:

### DECLARATION

### AIVIEOEMAVARAIVISOEMAAAROMS AROUS ROOMERAAIJEDAEVAARSI SAAMISINS

iscontium dispetites intermentary the yearly also unints to must accumate and correct double designamy knowledge

I confilm that have explicit consent, within the provisions of the Data Protestion Actalogs, to process my personal information with respect to this dam.

Patient's signature (Parent or guardian if patient is under 16)

Date

If you have any queries regarding your clair.	n. log onto our website www.bupa-intl.com	n/membersworld o	or contact our customer services team or
Telephone: +44 (0) 1273 323 563	o Fax: +44 (0) 1273-820 517		○ Email: info@bupa-intl.com

Email is used for your convenience and speed, but we cannot always guarantee the security of this method of communication. You need to be aware that some companies and countries do monitor email traffic. You need to take this into account when choosing to use this method of communication.



#### TAX INVOICE

**Reg TRN No** 

100529934000003

**Facility Name** 

DentisTree Dental Clinic

Address

P.O.Box 23581, Ground floor, Shop 3, Wast Port Views 8, Al Mina Road, Jumeirah 1, Dubai

042529935 / 045641764

Invoice No

INV-1C008467

Invoice Date

: 11-10-2024

Doctor

Department.

: Dental

Pearl Pinto

MRN#

**Patient Name** 

Dineshkumar Vinayagamoorthy

: 4156 : Cash

Age / Gender

34Y - 10M - 10D / Male

Type Inv. Time

: 18:57:54

**Visit Date** 

11-10-2024

SI No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	D2392	resin-based composite - two surfaces, posterior	4	500.00	1	500.00	0.00	o	0.0000	500.00
2	D2392	resin-based composite - two surfaces, posterior	5	500.00	1	500.00	0.00	0	0.0000	500.00
Gross .	Amount (in	AED)						<u> </u>	1	,000.00
Discou	Int (in AED)									0.00
Net Ar	nount (in Al	ED)		2) -2004 AC-Landers arrangement area	***************************************	************			1	,000.00
Tax on	5%(in AED)									0.00
Total A	lmount(in A	EO)		11:37	ماران برانده موسمون بران					1000.00
Paid (ii	n AED) (Credi	t Card)	***************************************	7/37	<b>\</b>		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		, <b>1</b>	,000.00
Balanc	e (in AED)	:			T Englis	igas Sistematikan		······································		0.00
Advan	ce Balance	(in AED)			5 50 50 5 40 55	i dingwija Koom i si	1327			0.00
Prepa	red By G	ayle	Richt 494646 Black Albertaine	1/200	an Leaders Since S	AE CO		TO THE PERSON NAMED IN COLUMN		7 - 1

#### **Patient Signature**

Kindly note that this automated and uniquely dated invoice is payable on this visit before leaving the Center deposit will be automatically deducted upon settlement.



1,000.00

#### RECEIPT VOUCHER (No.REC-1008382)

Date:11-10-2024

Receive from Mr./Mrs./M/s. 4156 - Dineshkumar Vinayagamoorthy

The sum of Dhs. One Thousand Dirhams and Zero Fils Only

By Cash 0.00 / By Credit Card 1,000.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank:

Cheque No.

Date: 11-10-2024

Being

Made by Gayle





PORT RASHID DUBAT PORT RASHID DUBAT PORT RASHID DUBAT PORT RASHID DENTISTREE DENTAL CLINIC

MID: 001000110690 TIME: 18:19:20

MASTERCARD(Contactless) 515537\*\*\*\*\*\*2701

RECEIPT No :012470

EMP: KX/XX
PAN SEQ No: 00
BATCH NO: 745
RECEIPT No: 012470
RRN: 001797001830
AMOUNT: AED 1000.00
PLEASE DEBIT MY ACCOUNT
NO SIGN REQUIRED FOR CONTACTLESS TXN
APPROVAL CODE: 679162

APPROVAL CODE: 679:
ALD: AGOGOGOGO41010
LABEL: MASTERCARD
TVR: 0000008001 TSI: ACCO
AC: 6FDFF147A499ADAD CID: 80
THANK YOU
CONE AGAIN

<<CUSTOMER COPY>>
APP VERSION:1.80