Chester House
Harlands Road
Haywards Heath
West Sussex RH16 1LR
Telephone: +44 (0)1444 444957
Facsimile: +44 (0)1444 450872

HEALTH INSURANCE CLAIM FORM

IMPORTANT: Please complete form in full, failure to do so may delay payment of claim. Proof of claim must be submitted within 90 days of first of accident of illness. In order for your health claim to be considered for reimbursement, you must complete and sign this claim form. Please mail or fax this completed claim form with itemized bills and receipts to the address or fax listed above. When mailing, please tape small receipts to on a letter or A4 paper. Please do not staple receipts to claim form. A separate claim form should be used for each patient and each medical condition.

Documents and signed claim forms can be scanned and emailed to: healthcare@lampinsurance.com

SECTION A: Member and Patient Information

Certificate Number: _____ Policy Holder's Name: _____

Policy Holder's D.O.B_____(dd/mm/yyyy) Name of Employer:_____

Mailing Address: _____ Street Address: _____

City:_____ Country: _____ State /Province: _____Postal/Zip Code: _____

Patient's Name:_____ Patient's Date of Birth: _____(dd/mm/yyyy)

E-mail address: _____

Gender: ☐ Male ☐ Female Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECTION B: Claim Information

Please indicate: Date of illness (first symptom)/injury (accident)/Pregnancy (last menstrual period:_____(dd/mm/yyyy)

Date of first consultation: _____ (dd/mm/yyyy)

The following information must be completed by either Member or Provider.

Foreign language claims: Member, please complete in English

Date of Service dd/m/yyyy	Place of Service *	Provider Name, Address & Phone Number of Provider	Fully describe treatment for each date given	Diagnosis	Charges & Currency	Type of Service **

*** Place of service**
21 – (IH) = Inpatient Hospital
22 – (OH) – Outpatient Hospital
11 – (OV) – Doctors Office
12 – (HV) – Patient's Home
8I – (IL) – Independent Laboratory

**** Type of Service Code**
1 – Medical
2 – Surgery
3 – Consultation
4 – Diagnostic Laboratory
5 – Anesthesia (Duration required)
6 – Assistance Surgery
7 – Other Medical Service

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SECTION C: Payment Options

REIMBURSEMENT: Payments are made in USD dollars unless other currency is requested and are subject to USD Exchange Rate of date service rendered.

ASSIGNMENT OF BENEFITS: ☐ Yes ☐ No (Yes, for direct payment to hospital or physician)
I hereby authorise payment to the hospital or to the physician as indicated on receipts. I understand that I am financially responsible for charges not covered by the policy. Payment will be made by Wire Transfer.

Please note your bank or other intermediary bank may assess a fee for the receipt of a wire transfer and that these fees are not reimbursable under this plan.

Please note that wire transfer may also be processed in other currencies, to request a different currency please indicate: _____

Beneficiary Name (s) (exactly as it appears on the account) _____

Bank Account No. _____ Bank Name _____

Bank Address _____

Bank Telephone No. _____ Swift Code/BIC _____

Account Currency _____ IBAN# _____

SECTION D: Policy holder or authorised person's Signature and Release

(Parent or Guardian, if claim is for a minor). I certify, to the best of my knowledge, that this Claim Form does not contain any false misleading or incomplete information. I authorise the release of all records or other information that may be necessary to determine benefits payable.

POLICY HOLDER OR AUTHORISED SIGNATURE _____ DATE_____(dd/mm/yyyy)