William Russell

Global Health Plans

Maternity Claim Form

Please complete Section A of this claim form yourself, and ask your physician to complete Section B.

Submit the completed form, with the fully itemised invoices for all treatment you have received, to claims@william-russell.com

We can only reimburse your claim when we have received copies of the fully itemised invoices, which give us a complete breakdown of all treatment you have received and any medication you have been prescribed.

We also reserve the right to request original documentation relating to your medical treatment, so please retain all original invoices and receipts for a period of 12 months.

A SECTION A

Section A is to be completed by the claimant, or the claimant's guardian or legal representative.

Claimant's personal details

Full name: …… Title: .....

Address: …… Plan number: .....

..... Date of birth: .....

Email address: ..... Telephone number: ……

Details of your pregnancy

On what date did you discover that you were pregnant? .....

Please provide the name of the physician who confirmed that you are pregnant: ……

.....

What is your estimated due date? .....

Please confirm how many previous pregnancies you have had: ……

At which hospital do you plan to give birth? ……

Do you plan to give birth by Caesarean Section? ☐ Yes ☐ No

Please list the bills for which you are seeking reimbursement

Date(s) of treatment	Details of the bills you have enclosed for reimbursement	Please state currency and amount paid

How you wish to be reimbursed

☐ **Payment to your VISA credit or debit card**

If you wish to be reimbursed to your VISA credit or debit card, you will need to complete our reimbursement form. This is for security and privacy reasons; while we will keep a record of your claim form, we will delete your card details once we have reimbursed you.

The reimbursement form can be found at: william-russell.com/wp-content/uploads/ANS_Claim_Reimbursement.pdf

☐ **Payment to your bank account**

Currency in which you would like to be reimbursed: ☐ US Dollars ☐ GBP Sterling ☐ Euros ☐ Other: .....

If you have previously submitted a claim, and you wish to receive reimbursement to the same bank account as before, please confirm the last four digits of your account number: .....

If you have not submitted a claim before, or you have submitted a claim before and you wish to receive reimbursement to a different bank account, please provide your account details below:

Bank name and address: .....

.....

.....

Account holder name(s): ..... Bank account number*: .....

Sort code: ..... IBAN number*: ..... BIC Number*:.....

** BIC and IBAN details are necessary for all transfers to European and UAE bank accounts. BIC and bank account number are necessary for all transfers to international bank accounts.*

Declaration and authorisation

Do you have any other health insurance cover? ☐ No ☐ Yes, with the following provider: .....

I hereby give William Russell Limited authorisation to correspond with me by email regarding my claim. I understand that these emails may contain reference to my medical condition(s) and financial payment information.

I consent to the use of this information by William Russell Limited for the purpose of: data processing, electronic or otherwise; assessing my claim(s); medical underwriting; and for disclosure to other medical professionals involved in my treatment or care, to William Russell Limited's medical officers and emergency assistance service providers (including those based outside the EU), to my medical insurers and reinsurers, and to the plan holder if other than myself. If required, we will pass your information to legal and regulatory bodies, and we may pass information to relevant third parties in the interests of fraud and money-laundering prevention.

I also authorise any physician, doctor or medicine, or any other health professional who has attended or examined me to furnish William Russell Limited and/or its authorised representatives any and all information with respect to my medical condition(s), illnesses and injuries, medical history, consultations, prescriptions, medical investigations, tests and treatment, and copies of all hospital/medical records.

Name of claimant*: ..... Date of birth: .....

Signature of claimant*: ..... Date: .....

*This should be completed by the claimant's parent or guardian **if** the claimant is a child under age 16, or by the claimant's next of kin if the claimant is unable to provide properly informed consent due to cognitive disability or otherwise, or if the claimant is deceased. Please also state your relationship to the claimant and provide contact information.

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B SECTION B

Section B is to be completed by the claimant's physician.

Patient's details

Full name: .....

Date of birth: ..... Nationality: ..... Gender: ☐ Male ☐ Female

Dates

Please confirm the date the patient first consulted you regarding this pregnancy: .....

Please confirm the date of the patient first registered at your facility: .....

Please state the expected delivery date: .....

Please state the date of the last monthly period: .....

Medical information

Please state diagnostic tests performed, the test results and your reason for performing the tests.

Date(s) of treatment	Tests performed	Reasons for tests

Was any medication prescribed? ☐ Yes ☐ No

If YES, please indicate which medication and why: .....

.....

Are you aware of any complications that may arise during this pregnancy? ☐ Yes ☐ No

If YES, please provide details: .....

.....

Please answer each of the following questions:

a	**Has the patient ever received IVF or any other treatment to assist fertility?**	☐ Yes ☐ No
b	**Is this pregnancy as a result of IVF or assisted fertility?**	☐ Yes ☐ No
c	**Has the patient previously been treated or hospitalised for any termination of pregnancy, miscarriage, complications of pregnancy, or suffered any complications during childbirth?**	☐ Yes ☐ No

If you have answered YES to any of the above, please provide full details: .....

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Declaration by physician

I declare that I am the patient's treating physician, and that the details given above are, to the best of my knowledge, full, true, accurate, and complete.

Signature of physician: ..... Date: .....

Print your name and address: .....

.....

.....

Email address: ....

Telephone number: ..... Fax number: .....

Qualifications: .....

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP BELOW:

William Russell Ltd.
William Russell House,
The Square, Lightwater,
Surrey, GU18 5SS, UK

T: +44 1276 486460
F: +44 1276 486476
E: claims@william-russell.com