



## 2. PLEASE STATE HOW YOU WISH TO BE REIMBURSED

If you have previously submitted a claim, are your payment details the same?  YES  NO/NOT APPLICABLE If YES go to part 3.

**PAYMENT TO YOUR VISA CARD** NB: We can only make payment to a visa card, and settlement can be provided in Sterling, Dollars or Euros.

Card number: \_\_\_\_\_

Name on card: \_\_\_\_\_

Expiry date (DD/MM/YY): \_\_\_\_\_

Address to which card is registered (If different from Section A): \_\_\_\_\_  
\_\_\_\_\_

**PAYMENT TO YOUR BANK ACCOUNT**

Currency in which you would like to be reimbursed: \_\_\_\_\_

Bank name and address: \_\_\_\_\_

Account holder name(s): \_\_\_\_\_

Bank account number\*: \_\_\_\_\_

Sort code: \_\_\_\_\_

BIC Number\*: \_\_\_\_\_

IBAN number\*: \_\_\_\_\_

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

**PAYMENT BY BANK DRAFT** NB: Payment by bank draft is subject to local bank charges. Please allow up to 4 weeks for delivery.

Name of the payee: \_\_\_\_\_

Currency of the bank draft: \_\_\_\_\_

Address to which card is registered (If different from Section A): \_\_\_\_\_  
\_\_\_\_\_

## 3. DECLARATION, AUTHORISATION AND CONSENT BY THE CLAIMANT OR HIS/HER LEGAL REPRESENTATIVE

Do you have any other health insurance cover?

NO, I have no other health insurance cover  YES, I have other health insurance cover with: \_\_\_\_\_

I hereby declare that, to the best of my knowledge and belief, all information provided in this claim form is accurate and complete. I hereby authorise any doctor of medicine, hospital or other person who has attended or examined me, to furnish to William Russell Limited or to their authorised representative, any and all information with respect to sickness or injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records relating to me (or to the claimant if I am the claimant's parent/legal guardian).

I accept that my personal details may be passed to selected third parties, such as cost agents and Third Party Administrators, for the sole purpose of assisting with the administration of my claim.

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.

Signature of claimant or guardian: \_\_\_\_\_

Date (DD/MM/YY): \_\_\_\_\_

Print name of claimant or guardian: \_\_\_\_\_

## SECTION C To be completed by the claimant's doctor

### 1. PATIENT DETAILS

Patient's full name: \_\_\_\_\_

Sex:  Male  Female

Date of birth (DD/MM/YY): \_\_\_\_\_

Was the patient referred to you?  YES  NO If YES, please state the name and contact details of the referring doctor: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 2. DATES

Please confirm the date the patient first registered at your facility (DD/MM/YY): \_\_\_\_\_

On which date did the patient first consult you for this particular condition (DD/MM/YY)? \_\_\_\_\_

Please give a short description of your client's symptoms or injuries, if they have suffered an accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In your professional opinion, for how long before this date would the patient have been aware of their symptoms? \_\_\_\_\_

### 3. YOUR DIAGNOSIS

What is your clinical diagnosis?

Please advise tests performed and attach test results:

### 4. YOUR TREATMENT PLAN

Please provide a treatment plan including details of medications currently being prescribed to this patient:

### 5. MEDICAL HISTORY

Please answer each of the following questions:

A. Has your patient previously suffered from this or from any related condition?  YES  NO

If YES, please give full details of the previous condition/related condition, and the dates on which it first occurred:

B. Does your patient have a history of any of the following: YES NO Details and date of onset:

High blood pressure, high cholesterol, heart or circulatory disorders?

Diabetes?

Asthma, respiratory or allergic conditions?

Spine, bone, joint or muscle conditions?

Cancer?

Psychiatric, psychological or mental disorders?

Any other disease or injury requiring in-patient treatment?

### 6. DECLARATION BY DOCTOR

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

Signature:

Date (DD/MM/YY):

Print your name and address:

Telephone:

Fax:

Email:

Qualifications:

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP

#### NOTE TO CLAIMANT OR GUARDIAN:

Once Sections A, B and C have been fully completed and signed, please send your claim form to our International Claims Team at the address in the United Kingdom below.



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Peace of mind wherever you are

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