World Pass
Claim form

INSURED DETAILS *(to be completed by the* **insured***)*

LAST NAME : ..... FIRST NAME : .....

FULL ADDRESS *(street, city, postal code, country)* : .....

TEL NO. : ..... EMAIL ADDRESS : ..... @ .....

DATE OF BIRTH : ..... POLICY NUMBER : .....

CLAIM DETAILS *(to be completed by the* **insured***)*

BENEFIT TYPE ☐ **SICKNESS** ☐ **ACCIDENT**

For sickness only Date of first symptoms : .....

☐ New medical condition ☐ Continuing medical condition

For accident only Date of accident : .....

TREATMENT TYPE ☐ **OUT PATIENT** ☐ **IN PATIENT** ☐ **PHARMACEUTICALS**

For in-out patient only Date of Consultation 1 : ..... Date of Consultation 2 : .....

☐ General Practitioner ☐ Specialist : ..... ☐ X-rays ☐ Laboratory exams

☐ Dental Care / Prosthesis ☐ Other Prosthesis / Optical ☐ Medical auxiliaries

For in-patient only Date of admission : ..... Date of discharge : .....

MEDICAL DETAILS *(to be completed by the* **Treating Doctor***)*

DIAGNOSIS (in full) : .....

(Please specify hereafter further details)

☐ Medical Certificate attached *(Please tick the box if a medical certificate is available and put it together with the present claim form)*

Practitioner Signature | **Practitioner Stamp** | **Insured Signature**

Date : .....

TREATING MEDICAL OFFICER (TMO) / REFERRING DOCTOR

Name : .....
Tel. : .....
Fax. : .....
Email : .....
Address : .....

HOSPITAL / MEDICAL FACILITY

Hospital Name : .....
Tel. : .....
Fax. : .....
Address : .....
.....

SUPPORTING DOCUMENTS *(to put together with the present Claim Form)*

☐ **Original Invoice(s)** ☐ **Proof of Payment** ☐ **Prescription** (for pharmaceucals) ☐ **Medical Referral** (for specialist)

IMPORTANT: Please ensure to submit ONE CLAIM FORM and all relative supporting documents for EACH and SINGLE DIAGNOSIS. This will greatly assist us in processing your claim. Thank you.