Claim Form

Please Return this form directly to LAMP:

email: sea@lamphealthcare.cn

Claim Reference Number (if known)	

Important Notes

- To assist us in processing your claim efficiently an speedily, please complete this form fully, clearly and legibly.
- Please complete sections A, B, C, and D
- The attending doctor should complete Section E.
- All claims should be submitted **within 60 days** of treatment.
- Please attach all original bills, retaining photocopies for your personal reference.
- A separate claim form should be used for each patient and medical condition.
- Processing of your claim may be delayed if the information provided is incomplete
- Please Return this form directly to Lamp at: **sea@lamphealthcare.com**

SECTION A - Lead Applicant's Details

Title	Mr ☐ Mrs ☐ Miss ☐ Other		
Forename (s)			
Family Name			
Policy Number		Date of Birth (dd/mm/yyyy)	
Address			
Post Code (if applicable)		Country	
Day Time Telephone		Evening Telephone	

SECTION B - Details of illness / injury

Please describe the nature of your illness / injury

Date of first Symptoms (dd/mm/yyyy)	

If your injury or illness has resuletd from an accident, please provide details of the circumstances along with names, addresses and telephone numbers of any third parties and witnesses involved. If the accident was reported to the police please provide the report date, the report number and the police station details.

Is this a continuation of a previous claim? If yes, please provide details: Yes ☐ No ☐

Do you have any other insurance which covers the same incident, If Yes, please provide details: Yes ☐ No ☐

Please confirm details of your family doctor (or attending doctor):

Name			
Address			
Telephone		Fax	

LAMP

SECTION C - Details of expenses incurred

Please give details of accounts (invoices) included with this claim:

Date	Nature of Expense	Currency	Amount Paid
	Total Amount		

If you provide your bank details below, once approved, we will settle the claim by direct bank transfer.
If you leave this blank we will settle the claim by cheque

Name of Bank	
Address of Bank	
Country of Bank	
Name of Account Holder	
Account Number	
Bank Sort / SWIFT Code	
IBAN (international Bank Account number)	

SECTION D - Declaration

I/We confirm the facts stated on this form to be true and accurate to the best of my/our knowledge. I/We give authority to the insureres or their representatives to contact my/our Medical practioners for any additional information required in connection with this claim.

Signed	
Date (dd/mm/yyyy)	/ /

LAMP

SECTION E - To be completed by the attending doctor

Please indicate the date on which the patient first consulted you for this illness and/or any other related illness.

Details of any referring doctor:

Diagnosis and ICD 9 code applicable

Do you believe the patient has treatment for this or any previous related illness?
If Yes, please specify:

In the event of maternity claims, please specify: Yes ☐ No ☐

Estimated date of delivery: / /

Date of Menstrual Period: / /

Name	
Address	
Signature	
Date (dd/mm/yyyy)	/ /

Hospital / Practice Stamp

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