



JWS Worldwide Healthcare

Individual and Group Claim Form

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Please complete this form in block capitals.

For all sections please ensure you give an answer to every question. An incomplete form will delay the processing of your application.

- Section A needs to be completed by the patient or patient's legal guardian
- Section B needs to be completed by the treating doctor/dentist

1. Section A

A. APPLICANT

Insured person's full name Title: Mr / Mrs / Miss / Ms / Dr				
First Name(s)			Last Name(s)	
Postal Address (Is this a recent change of address?) Yes <input type="checkbox"/> No <input type="checkbox"/>				
Post Code		Contact No.		Fax No.
Nationality		Membership No.		Date of Birth (DD/MM/YY)
Email Address				
Is this your first claim for this medical condition? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you claiming for cash benefit Yes <input type="checkbox"/> No <input type="checkbox"/>				
Please describe the medical symptoms or event you wish to claim for				
Diagnosis (if known)				
How long have you had these symptoms before consulting your doctor?				
Are you injured or ill as a result of an accident (e.g. a road accident or an accident at work) or are you considering making a personal injury claim against someone else? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Do you have any other insurance for this type of claim ? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Please supply				
Dates of Treatment	List of expenses for which you are claiming	Currency and amount paid	Who would you like us to pay?	Preferred currency
Please enclose original invoices (not receipts or photocopies) with this form. We will keep these for audit purposes so please make copies for your records				
If you would like us to pay the settlement directly into your account please give us the				
Account holder(s) Name(s)				
Bank Name			Branch Name	
Account No.			Sort code	
Bank address				
SWIFT code			or IBAN No.	
Insured person's declaration				
<p>I declare that to the best of my knowledge and belief, the information given on this form is true and complete. I understand and accept that in the event of this claim form being fraudulent in whole as or in part, the policy will be invalidated and I will be liable for prosecution.</p> <p>I hereby authorise any doctor or hospital to release such medical information as the Insurer, or its authorised Assistance Services may require for assessing my claim under this Insurance Plan.</p> <p>I have read and understood the membership guide <input type="checkbox"/> I have read and understood the important claim information <input type="checkbox"/></p>				

Signature	Date (DD/MM/YY)
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2. Section B

B. SPECIALIST/DOCTOR	This section is only admissible if it is completed by the specialist or referring doctor who is registered and licenced to practice in the country where you receive treatment . We reserve the right to withhold benefit for treatment by doctors who do not hold internationally recognised qualifications and training (for example, a medical school listed in the World Health Organisation's World Directory of Medical Schools).	
	Please give description of symptoms and date of onset and diagnosis	
	Please tell us when the patient first consulted a doctor for this or similar symptoms (DD/MM/YY)	
	Has the patient received any treatment , had any need for treatment or required medication and/or advice for this condition in the past 2 years? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	To whom are you referring this patient? (if applicable)	Name
	Specialisation	Date referred (DD/MM/YY)
	What is the likely treatment plan and procedure to be performed?	
	Hospital admission must be pre-authorised by us	
	Name of hospital	Proposed admission date (DD/MM/YY)
	Address of hospital	Expected hospital stay (if known)
	Declaration	
	I hereby certify that I am the patient's doctor	
	Practice stamp	
	Signature	Date (DD/MM/YY)
	Telephone No.	Fax No.
Email address		
Name and Address		
Dental Claims		
This section may only be completed by a dentist or surgeon who is trained, qualified and licensed to practice dentistry by the licensing authority of the country in which you receive treatment		
Please provide the dental history for the last 12 months		
What treatment has been received by the patient?		
Has all necessary treatment been concluded? Yes <input type="checkbox"/> No <input type="checkbox"/> If not please list planned treatment ?		
If this is a claim for restorative treatment after an accident, we will write to you requesting the information we need		
Practice stamp		
Signature of dentist or surgeon	Date (DD/MM/YY)	
Telephone No.	Fax No.	
Email address		
Name and address		

Please send claim form to

For all **out-patient** claims Worldwide
 For all **in-patient** claims within East Africa*
 For all assistance services within Africa

For all **in-patient** claims outside East Africa*
 For all assistance services outside Africa

*East Africa: Kenya, Uganda and Tanzania

JWS Worldwide Healthcare
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Important Claim Information - Please read

- You must get our **pre-authorisation** before making certain claims. Please refer to your membership guide
- You must send us the **claim** form within 90 days of the start of the **treatment**
- We recommend that you phone the **Assistance Services** before you start any **treatment**, so they can confirm the extent of your cover and help guide you through the claims procedure
- Please complete a separate **claim** form for each unrelated medical condition and for each **insured person**