Claim Form

GOODHEALTH℠
An Aetna Company

Executive Healthcare Plan

Please ensure Your Claim Form is completed in full and returned within six months of Your initial Treatment. Failure to complete Your form in full will result in the form being returned to You and will hold up the processing of Your claim. Please note Goodhealth is not responsible for any costs associated with the completion of this form or for any further information/documents requested by Us to assess Your claim. The issuing of this Claim Form is in no way an admission of liability.

Policyholder: Policy Number:

Section A: Patient's Details - To be completed by the member

Family Name:
First Name and Initials:
Date of Birth: day month year
Contact Telephone Number:
Do You hold any other insurance? Yes No
If Yes, please provide full details on a separate sheet

Address:
Email:
Fax/Mobile:
Were Your injuries caused by an Accident? Yes No
If Yes, please provide full details on a separate sheet

Section B: Claims Settlement - To be completed by the member. It is essential that all information is completed if We are to complete an international transfer.

Total amount claimed, including currency of claim:
Currency in which You wish settlement to be made:
State to whom You wish settlement to be made, if different to the member:
Address to where settlement to be sent:

- *Please note payment may not have been credited to Your bank account at the time You receive Your Advice from Us. You will need to check with Your bank.*
- *If settlement is to be sent care of Your Bank or by transfer, please give full details of Your bank opposite:*

Bank Name and Address:
Account No./ Sort Code:
Account Name:
BIC (Swift) Code:
ABA routing no. (USA Banks only):
Correspondent bank details (if applicable):

Section C: Declaration

"I declare that all information, to the best of my knowledge, provided on this Claim Form is truthful and correct. I also understand that this declaration gives permission to Goodhealth and their appointed representatives to approach any third party for information required to complete their assessment of this claim including, but not limited to, my current and previous Medical Practitioners."

"I declare and agree that the personal information collected or held by Goodhealth, whether contained in this claims form or otherwise obtained may be used by Goodhealth, or disclosed to or transferred to any organisation within the Aetna Group (of Companies), their suppliers and partners, worldwide for the purpose of 1) providing on-going insurance and customer service, 2) processing and giving effect to credit card payment, 3) generating statistics to provide marketing material in respect of insurance-related services of Goodhealth or it's associated companies and 4) processing claims or analysing the insurance".

Patient's Signature:
(If patient is under 18 years of age, Parent or Guardian must sign)
Date: day month year

Section D: Claims Information - To be completed by the patient's Medical Practitioner or Dental Practitioner

Details of Medical Condition requiring Treatment: *(Please provide the precise diagnosis, if known).*
Underlying cause:
If this claim is for maternity, please advise whether the pregnancy is as a result of any form of assisted conception:
How long has this condition existed:
When did the patient first become aware of any symptoms prior to seeking medical Advice?
Date of first consultation with any practitioner for this condition:
Has this, or any similar condition previously been suffered from?
Please confirm the likely period of Treatment and prognosis (if known):
Name and address of referring Doctor/Dentist:

Please complete only if the patient has been referred to You

Please detail any diagnostic tests performed and attach the results:

This question relates to dental Treatment only Is this claim for a routine check-up? Yes No

If You have insufficient space in any section, please provide full details on separate sheet

Section E: Medical Practitioner or Dental Practitioner details - To be completed by the patient's Medical Practitioner or Dental Practitioner

Name of Practitioner:
Address of Practitioner:
Tel: Fax:
Email:
Practitioner's Signature:
Date: day month year

Official Stamp

IMPORTANT - Please ensure

1 All original receipts and prescriptions are attached
2 The Claim Form is completed in full
3 The declarations are signed and dated
4 All laboratory tests are attached
5 The diagnosis and underlying cause have been confirmed

This will ensure that Your claim is reviewed in a timely fashion.

Important Note - Please ensure that all costs for non-Emergency In-Patient/Day-Patient Treatment, all MRI and CT Scans are agreed by Us, on Our Helpline, or in writing (fax/email/letter) before any planned Treatment is undertaken. Planned Treatment undertaken without pre-authorisation from Us will not be covered. A verbal confirmation does not constitute pre-approval. If in doubt, please contact the Medical Helpline, as shown on Your Membership Card.

PLEASE NOTE: A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH CONDITION CLAIMED.

Planned In-Patient and Day-Patient Treatment

In the event of a planned admission on an In-Patient or Day-Patient basis to a Hospital, the following steps must be taken. Payment of all expenses incurred by You will not be recoverable unless You follow these procedures.

i) Contact Our Medical Helpline as soon as reasonably possible prior to admission giving full details of the condition, proposed Treatment including dates and name of procedure (if known) together with the name of the Specialist and Hospital details. (The telephone number is provided on the back of Your membership card).

ii) The Medical Helpline will advise You if they have sufficient information to confirm Your cover. If not, they will advise You what further information is required.

iii) When sufficient information has been made available to appraise Your claim, the Medical Helpline will verbally confirm the basis of Your cover and will despatch written confirmation to You.

iv) The Medical Helpline will attempt at all times to make arrangements with the Hospital for all eligible bills to be settled directly. Where this has been arranged, You should send the original Claim Form and any unpaid invoices (if given to You by the Hospital) to Your Goodhealth Claims Service.

v) Please ensure a new/separate Claim Form for each member, each new Medical Condition and each admission to Hospital, is submitted.

Out-Patient Treatment

If You receive medical Treatment as an Out-Patient, outside of Our Provider Network, Treatment must be paid for in full by You at the time of the appointment and re-claimed from Us. In such circumstances, please ensure that a Claim Form is completed by You and the Medical Practitioner or Specialist. Please remit this to Your Goodhealth Claims Service with all substantiating proof of Your claim, including but not limited to, the original invoice(s) and proof of payment, prescription and a written diagnosis from the Medical Practitioner.

Please return Your Claim Form to one of the following offices:

Executive Healthcare Solutions Limited

10th Floor, IPS Building
Kimathi Street
PO Box 51343
00200 - City Square
Nairobi, Kenya

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