Insurance Copy

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شركة رتاج للتأمين التكافلي (ش.م.ك.م)
Ritaj Takaful Insurance Company (K.S.C.C)
Sharq, Ahmad Al-Jaber Street, P.O.Box: 53056 Al-Nuzha, 73061 Kuwait, Ph No. (965) 830033, Fax: 2438981, E-mail: info@ritajins.com

DENTAL CLAIM FORM

Please fill in the following form correctly and completely to enable the Company to process your claim promptly.

TO BE COMPLETED BY MEMBER/CLAIMANT

1. **Name of the Company/Main Member** _____ **Policy Number** _____
   (In whose name the policy is issued, Name of the Company in case of Group policy)
2. **Details of the Insured Person/Member** (In respect of whom claim is made for)

Patient's Name		**Membership No. (UHID No.)**	
Gender : Male ☐ Female ☐		**Employee Number (Policy Group):**	
Date of Birth (D/M/Y)		**Other Medical Insurance Coverage- Yes / No (If Yes attach details)**	
Telephone Number			
Relationship with the Insured :			
Patient Address :			

3. **Medical Provider Name :** _____
4. **Medical Provider Address :** _____
5. **Date of Treatment :** _____

TO BE COMPLETED BY TREATING DOCTOR

6. **Details of Disease/Illness contracted or injury suffered :** _____
7. **Date of commencement of illness or injury sustained :** _____

Type of Treatment	Amount	Type of Treatment	Amount
Extraction		Filling	
Neurectomy		Gum Treatment	
X-ray		R.C.T.	
Cleaning		Scaling	
Bridge		Orthodontics	
Dentures		Crown	
Restoration		Prophylaxis	
Others		TOTAL CLAIMED AMOUNT	

8. **Other Investigations done :** _____

9. **Name of the Doctor :** _____ **Tel No. :** _____

Signature : _____ **Seal of Doctor :** _____

MEMBER'S/HOSPITAL'S DECLARATION

I/We hereby warrant the truth of the foregoing particulars in every respect. I/We agree that if I/We have made or shall make any false or untrue statement, suppression or concealment, my/our right to claim reimbursement of the said expenses shall be absolutelly forfeited. I/We hereby authorise Ritaj Takaful Insurance Co./WAPMED TPA services or their authorized representatives to check all the medical records related to treatment from the Doctor/Hospital.

Member's Signature : _____ **Hospital's Signature :** _____

Date : _____ **Seal of Hospital :** _____