D-0002

Insurance Copy

شركـة وربـة للتأميـن ش.م.ك

WARBA INSURANCE COMPANY K.S.C

Ahmad Al-Jaber Street, Sharq, PO Box: 24282, Safat-13103, Kuwait Ph No.- (965) 808181, Fax: 2466131

DENTAL CLAIM FORM

Please give the following information 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** ____________________
   (In whose name 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)

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

3. **Name of the Hospital** : ____________________
4. **Address of Hospital** : ____________________
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** : ____________________, **Tele No.**: ____________________

   Sign of Doctor : ____________________, **Stamp 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 absolutely forfeited. I/We hereby Warba / WAPMED or their authorized representatives to check all the medical records related to treatment from the doctor/Hospital.

Member's Signature: ____________________ **Hospital's Signature:** ____________________

Date: ____________________ **Stamp of Hospital :** ____________________

For any queries kindly contact-

Ahmad Al-Jaber Street, Sharq, PO Box: 26739, Safat-13128, Kuwait Ph No.- (965) 2466247/8, Fax: 2466234, email- info@wapmed.net, visit: www.wapmed.net