WETHAQ MEDICAL INSURANCE SCHEME
MEDICAL CLAIM FORM

PART 1

To be completed by Employee / Patient :

Submit this form with original document(s) within 90 days of the expenditure being incurred.

Your claim will not be considered if not submitted within the above Period.

A NEW CLAIM FORM IS REQUIRED EACH TIME YOU SUBMIT ACCOUNTS

POLICY NO. _____ POLICYHOLDER : _____

Group Member's Name : _____ Membership No. : _____

Patient's Name : _____ Patient's date of birth : _____

If Patient is not the Group Member, tick relationship :- Wife ☐ Husband ☐ Child ☐

For an in-patient stay in hospital, please enter date(s) of admission and discharge — Admission Date ☐ Discharge Date ☐

Is the cost of this treatment also covered by any other Insurer? YES ☐ NO ☐

Was the treatment as the result of an accident? YES ☐ NO ☐

If the answer to either question is YES, please give full details,

TOTAL CLAIM AMOUNT ☐ CURRENCY ☐ EXCH. RATE ☐

I hereby claim for costs of treatment and declare that, to the best of my knowledge and belief, all information given in support of this claim is true and complete.

Group Member's Signature : _____ Date : _____

PART 2

To be completed by Doctor / Specialist who carried out the treatment.

Please complete this form in BLOCK CAPITALS

Conditions requiring treatment / complaints : _____

Date of Commencement of illness : _____

Date of first treatment : _____

If Pregnant, Expected Date of Delivery : _____

Investigations : _____

Medicines Prescribed : _____

Final Diagnosis : _____

Doctor / Specialist's Signature & Stamp _____ Date _____

Note : Please attach originals of all relevant invoices, receipts and prescriptions. The amounts not supported by original documents shall not be considered as part of your claim. In case of Hospital admission, provide us with detailed medical report and detailed bills paid.

شركة وثاق للتأمين التكافلي [ش.م.ك]
ص.ب. 371 الصفاة 13004 الكويت
ت: ٢٤٦٨٣١٠ ف: ٨٦٦٦٦٢
Wethaq Takaful Insurance Company [K.C.S.]
P.O.Box 371, Safat 13004, Kuwait
Tel.: 866662, Fax : 2468310
www.wethaq.com

Insurance License No. 25, Reg. In accordance with Insurance Companies & Agents Law No. 24 for 1961 Registration No.82421. Authorized & paid capital K.D. 5,250,000/-
ترخيص التأمين رقم ٢٥, شركة خاضعة لأحكام قانون الشركات ووكلاء التأمين رقم ٢٤ لسنة ١٩٦١. السجل التجاري رقم ٨٢٤٢١. رأس المال المصرح به والمدفوع ٥،٢٥٠،٠٠٠/- د.ك

WETHAQ MEDICAL INSURANCE SCHEME
DENTAL CLAIM FORM

PART 1

POLICY NO. _____ POLICYHOLDER : _____

To be completed by Employee / Patient :

Group Member's Name : _____ Membership No. : _____

Patient's Name : _____ Patient's date of birth : _____

Submit this form with original document(s) within 90 days of the expenditure being incurred.

If Patient is not the Group Member, tick relationship :- Wife ☐ Husband ☐ Child ☐

For an in-patient stay in hospital, please enter date(s) of admission and discharge — Admission Date _____ Discharge Date _____

Your claim will not be considered if not submitted within the above Period.

Is the cost of this treatment also covered by any other Insurer? YES ☐ NO ☐

Was the treatment as the result of an accident? YES ☐ NO ☐

If the answer to either question is YES, please give full details,

A NEW CLAIM FORM IS REQUIRED EACH TIME YOU SUBMIT ACCOUNTS

TOTAL CLAIM AMOUNT	CURRENCY	EXCH. RATE

I hereby claim for costs of treatment and declare that, to the best of my knowledge and belief, all information given in support of this claim is true and complete.

Group Member's Signature : _____ Date : _____

PART 2 : To be completed by the Doctor (Please write visibly / thanks)

Date of Commencement of illness : _____

Date of first treatment : _____

Type of treatment		Amount	Type of treatment		Amount
1. Extraction	( )	.....	8. Filling	( )	.....
2. Neurectomy	( )	.....	9. Gum treatment	( )	.....
3. X-ray	( )	.....	10. R.C.T.	( )	.....
4. Cleaning	( )	.....	11. Scaling	( )	.....
5. Bridge	( )	.....	12. Orthodontics	( )	.....
6. Dentures	( )	.....	13. Crown	( )	.....
7. Restoration	( )	.....	14. Prophylaxis	( )	.....

Other treatment (s) (Please specify the nature) : _____

Medicines prescribed : _____

Doctor / Specialist's Signature & Stamp _____ Date _____

Note : Please attach originals of all relevant invoices, receipts and prescriptions. The amounts not supported by original documents shall not be considered as part of your claim.

www.wethaq.com

ت: ٨٦٦٦٦٢ ف: ٢٤٦٨٣١٠

Tel.: 866662, Fax : 2468310

ص.ب. 371 الصفاة 13004 الكويت

P.O.Box 371, Safat 13004, Kuwait

شركة وثاق للتأمين التكافلي [ش.م.ك]

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