TAKAFUL

Medical Claim Reimbursement Form

Please Use BLOCK letters to fill this form and ensure that all sections are completed.

Part 1 - Member Information

Member name (as printed on the card)		
Member card number		DOB
Principal member name (Employee Name)		
Principal member's contact information	E-mail:	Mob:

Part 2 - Medical Information
(To be fully completed by the patient's medical practitioner - all boxes must be completed in BLOCK letters.)

Country of treatment	Provider name and contact information
Date when first symptoms were noticed	Physician name and contact information
I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.	Physician signature and official stamp Date / /
Please provide details of diagnosis (primary and secondary) or symptom(s) and prescribed treatment(s) or investigation(s). Symptoms: Diagnosis: Treatment / investigation:	

Patient name	Card number

Arabian Scandinavian Insurance Company PLC - ASCANA Takaful
Head Office: P.O. Box 1993, Dubai, United Arab Emirates. Tel: 800 ASCANA (800-272262) Fax: +971 4 282 5586
Email: customercare@ascanatakaful.ae
Web: https://ascanatakaful.ae/

Section 3 - Claimed Invoices

No.	Invoice number	Claimed amount	Currency	No.	Invoice number	Claimed amount	Currency
Total claimed amount per currency:							

Section 4 - Settlement (Kindly ensure Principal members' bank details are provided)

Settlement Type: ☐ Cheque ☐ Wire Transfer	
(A) Bank name	(B) Account holder name
(C) IBAN number / Account number	(D) SWIFT code
(E) Bank address	(F) Beneficiary address

Important Notes:

Please submit the claim documents as per the checklist published at our download center https://ascanatakaful.ae/download-center/.

In case of online submission, please retain the original documents as they are required to finalize your claim and release payment

Prior approval is required for all non-emergency hospitalizations. Before admission, you are kindly required to e-mail a detailed medical report and cost estimate of the proposed treatment on official letterhead duly signed and stamped by the treating physician to customercare@ascanatakaful.ae

Cheques are issued in the name of the principal and are valid for 6 months from the date of issue.

For your convenience, bank account details can be shared to opt for a bank transfer.

For transfers within the U.A.E., fields (A), (B), and (C) are mandatory in Section 4. For transfers outside the U.A.E., please complete all fields in Section 4 above.

In case IBAN is not available in the destination country, please enter the bank account number in lieu of the IBAN number. Please note that transfers outside the U.A.E. are subject to charges that may be applied by your bank.

ASCANA Takaful bears no liability for any incorrect bank account details provided above. Furthermore, any charges related to corrective action shall be deducted from the final settlement.

All Documents must be submitted in English or Arabic, and documents in other languages must be translated prior to submission.

I, the undersigned, confirm that I am the patient/patient's spouse or guardian (if the patient is under 18years of age) and I wish to claim benefits and declare that all the particulars given above are to the best of my knowledge to true and correct. In addition, I authorize and request any hospital, physician, and any other health provider to furnish ASCANA Takaful with the complete information including copies of their records in connection with medical treatment and/ or other services provided to me or to my dependent. I also agree that a copy of this consent shall have the validity of the original.	Signature of the principal and /or spouse Date: / / 20