

Return this form with original invoices to: Shell Account, PO Box 340, Russell House, Russell Mews, Brighton BN1 2WS United Kingdom

Please ensure that all sections of the claim form are fully completed. Please note that claims payment may be delayed if all sections of the claim form are not completed in full. The form should be returned to us within six months of the initial treatment date. Always enclose the original invoices - photocopies, receipts and credit card vouchers are not acceptable.

Please complete a new / separate claim form:

● for each patient ● for each in-patient / day-case stay ● for each medical condition ● for each currency

If you have more invoices, you do not need to send a further claim form.

Just send the invoices with a covering letter stating the condition and payment instructions.

If the condition continues for more than six months we may request a new claim form to be completed.

Unless you request the return of your documents, they will be microfilmed and destroyed

1 Patient's details - to be completed by the person undergoing treatment

Patient membership number

Group name (if applicable)

BI	-																							
Title										Family name														
First and middle names																								
Date of birth					day					month					year					Age last birthday				

Correspondence address

Address Line 1																								
Address Line 2																								
Address Line 3																								
Town/City																								
Post/Zip Code										Country														
Telephone number										Daytime					Evening					Fax number				
Is this your permanent residency address? Yes <input type="radio"/> No <input type="radio"/> E-mail																								
Do you want all future correspondence sent to this address? Yes <input type="radio"/> No <input type="radio"/>																								

Please tick this box if you have a residence in the USA: ☐

In which country did the treatment take place?

What is the currency of the invoice?

What is the total amount of the claim?

2 Medical details (all sections must be completed by the doctor in overall charge of the patient's treatment)

Medical practitioner's details

Name																			
Address																			
Qualifications																			

BLOCK CAPITALS PLEASE

Diagnosis																			

Onset date when symptoms first noticed by the patient										When did the patient first see a doctor?									
D D M M Y Y										D D M M Y Y									

Details of treatment																			
Details of operation																			
Details of medication																			

Hospital dates D D M M Y Y

Admission date

Discharge date D D M M Y Y

Name and address of admitting hospital

Name										Reference number									
Address																			
Telephone number										Fax number					E-mail				

Medical practitioner's signature X

Date X

3 Payment details

We can settle claims in over 80 currencies. In the few cases where we cannot settle in the currency requested, we will reimburse you in the currency of your subscriptions.

Who should we pay? (please tick) Doctor/Hospital ☐ Patient ☐ Principal Member ☐ Group ☐

Would you now please complete either Section A or Section B

SECTION A - Payment by Cheque

In which currency should we pay the cheque? (please tick)

Currency of the invoices ☐

Currency in which you pay your subscriptions ☐

Currency of your bank account ☐

Please specify this

Cheques payable to members will be sent by post to the correspondence address provided on the previous page.

SECTION B - Payment by Electronic Funds Transfer to a bank account

Bank name												
SWIFT/BIC Code*						Sort Code (UK only)			-		-	
Account number/IBAN												
Account name/Payee												
Currency for the transfer (see below)												
Bank address												
Post/Zip code						Country						

***In order to process your payment as quickly and securely as possible, we strongly recommend that you provide the SWIFT code of your bank branch. Your bank will be able to provide you with this information if necessary.**

We recommend that bank transfers are made in the currency of your bank account.

If you have asked us to pay the provider, and an annual deductible applies to your cover, the deductible will be collected using your direct debit or credit card.

Payment by bank transfer or the banking of cheques may result in charges over which we have no control and these will be the responsibility of the beneficiary.

If we are unable to pay direct to a bank account, or no account details are provided, we will pay by cheque.

We reserve the right to send any benefit due to an appropriate person - for example, the executors of the will of someone who has died or the dependant on your membership who has paid the bill.

4 Your consent to obtain a Medical Report

Please read this section carefully, as it sets out your rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (NI) Order 1991.

In order to process your claim, we may need to apply for a medical report from any doctor who has attended you. To apply, we need you to give your consent by signing the declaration below.

You can choose from three courses of action:

1. You can give your consent without asking to see the doctor's report before it is sent to us. The report will then be sent directly to us by the doctor.
2. You can give your consent, but ask to see any report before it is sent to us, in which case you will have 21 days, after we notify you that we have requested a report from the doctor, to contact your doctor to make arrangements to see the report. If you fail to contact the doctor within 21 days, he will be entitled to send the report direct to us. If however you contact your doctor with a view to seeing the report, you must give the doctor written consent before he can release it to us. You may ask your doctor to change the report if you think it is misleading. If your doctor refuses, you can insist on adding your own comment to the report before it is sent to us. Should you give your consent to us obtaining a report without indicating that you wish to see it, you can change your mind by contacting your doctor before the report is sent to us, in which case you will have the opportunity to see the report and ask the doctor to change the report or add your comments before it is sent to us, or withhold your consent for its release.
3. You can withhold your consent but, if you do, please bear in mind that we may be unable to accept your claim.

Whether or not you indicate that you wish to see the report before it is sent, you have the right to ask your doctor to let you see a copy, provided that you ask him within six months of the report having been supplied to us.

Your doctor is entitled to withhold some or all of the information contained in the report if (a) he feels that it may be harmful to you or (b) it would indicate his intentions in respect of you or (c) would reveal the identity of another person without their consent (other than that provided by a health professional in their professional capacity in relation to your care). Your doctor may also make a reasonable charge for his services.

The undersigned authorises and requests any hospital, specialist, physician or other health provider to furnish Bupa or its duly authorised agent acting on Bupa's behalf with such information as Bupa or that agent may seek from them in connection with any treatment or other services provided to me or my dependant for the purpose of Bupa considering this claim.

I have been advised of my rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (NI) Order 1991.

I do (not)* wish to see a copy of any medical report before it is sent to Bupa. (Delete the word NOT if you wish to see a copy of the medical report before it is sent to Bupa).

Bupa International Data Protection Notice

Purpose: Personal data collected on you, and where appropriate, your family, will be used by Bupa International to process your claims, administer your policy and may be used to detect and prevent fraud or improper claims.

Confidentiality: The confidentiality of patient and member information is of paramount concern to the companies in the Bupa Group. To this end, Bupa fully complies with Data Protection Legislation and Medical Confidentiality Guidelines. Bupa sometimes uses third parties to process data on its behalf. Such processing, which may be undertaken outside the EEA, is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

Medical Information: Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your General Practitioner/Primary Health Physician, or to their agents, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents. Claims information may be discussed with the Bupa International Agent/Adviser where you have requested the Adviser to assist you.

Member details: All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the principal member.

Telephone calls: In the interest of continuously improving our service to members, your call will be recorded and may be monitored.

Research: Anonymised or aggregated data may be used by Bupa International, or disclosed to others, for research or statistical purposes.

Fraud: Information may be disclosed to others with a view to preventing fraudulent or improper claims.

Names and Addresses: Bupa does **not** make the names and addresses of members or patients available to other organisations.

Keeping you informed: Bupa would, on occasion, like to keep you informed of Bupa products and services which it considers may be of interest to you.

Contact Address: If you do not wish to receive information about Bupa's products and services, or have any other Data Protection queries please write to the Bupa Group Information Protection Manager, at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA or at DataProtection@Bupa.com.

Are some of the costs recoverable from someone else (for example, another insurer or a person/organisation involved in an accident?)

YES ☐

NO ☐

If your answer is YES, please let us have full details in a covering letter.

5 Declaration

DECLARATION to be completed by the patient.

I confirm that the information I have given on this form is accurate and correct, to the best of my knowledge.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, to process my personal information with respect to this claim.

Patient's signature. Parent or guardian if patient is under 16.

Signature X

Date X

If you have any queries regarding your claim log on to our web site www.bupa-intl.com/membersworld

or contact our customer services team on: Telephone +44 (0) 1273 718393 Fax +44 (0) 1273 866577 E-mail: shellus@bupa-intl.com.

Email is used for your convenience and speed, but we cannot always guarantee the security of this method of communication. You need to be aware that some companies and countries do monitor email traffic. You need to take this into account when choosing to use this method of communication.