Freedom Worldwide health insurance
Outpatient dental treatment claim form

Please remember these important points when completing your claim form:

1. Complete this form in full to avoid any delay in payment of your claim. If you wish to make more than one claim, you can print and complete as many section 3 pages as required (one for each person) but the remaining sections only need to be completed once.
2. You must send a clear and complete copy of the original itemised invoice for each amount paid when you send your claim and a copy of the prescription if you are claiming for medication costs. Receipts and credit card statements will not be accepted.
3. Send your claim to us as soon as possible but no later than six months after the treatment.

If you need any assistance with your claim, call Freedom Health Insurance on +44 (0) 1202 756 350 or email intclaims@freedomhealthinsurance.co.uk.

1. Policyholder's details – to be completed by the policyholder

Policy number (found on your certificate of insurance):	
Surname:	First name(s):
Date of birth:	
Daytime phone number (incl. country code and area code):	
Evening phone number (incl. country code and area code):	
Email address:	

2. Payment details

If you have already paid the invoices yourself, we will reimburse you by bank transfer directly to your bank account as this is the quickest and safest method of reimbursement. We can also reimburse by cheque (UK payments only) but payment will take longer to reach you. Cheques will be paid to the policyholder and sent to the address shown on the certificate of insurance. We cannot reimburse to credit or debit cards.

Preferred payment method (please tick): Bank transfer ☐ Cheque (UK payments only) ☐

2.1 Bank transfer – please complete this information for bank transfer payments.

Bank name:	
Bank address:	
Account holder's name(s):	
Account number:	
Sort code:	
BIC/Swift code:	
IBAN number:	

The information required can vary depending on the country your bank is based in. If you need assistance, speak to your local branch. Make sure your bank account can receive foreign currency wire transfers and be aware we will not be responsible for any shortfall in reimbursement caused by exchange rate fluctuations or charges made by your bank.

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Sheung Wan, Hong Kong

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3. Claim details (complete one for each person / each condition)

Make sure all information you give us in this section is true, accurate and complete. If we later discover it is not, we reserve the right to refuse your claim and recover any monies already paid out. We may also cancel your policy.

3.1 Patient's details (if different) – to be completed by the policyholder if the patient is 18 or under

Surname:	First name(s):
Date of birth:	

3.2 About the claim

a) Why did you go to the dentist? For example, was it for a routine check-up or for planned treatment?
b) What treatment did the dentist carry out?
c) Has the dentist recommended any further treatment? If yes, what treatment has he recommended? Include a copy of the cost estimate.
d) If no further treatment is required, when is your next dental check-up?

4. Details of the medical expenses you are claiming for

All invoices and proof of payments related to this claim should be attached along with copies of relevant dental reports, certificates, prescriptions, and other correspondence. Invoices should be on headed paper clearly showing the name, address and contact details of the relevant dental practitioner or facility where treatment was received.

Name of dentist or dental clinic	Treatment received (e.g. check-up, scale and polish, filling)	Date of treatment	Amount of the bill	Has this bill been paid?
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No

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5. Declaration – please read this section before signing section 6 below

I declare, to the best of my knowledge and belief, all details given on this form are true, accurate and complete and I have not missed out any details relevant to this claim or provided false, misleading or incomplete information. I agree that, if this claim is found to be fraudulent, in whole or in part, I may be committing a criminal offence and this may invalidate the policy and make me liable to prosecution.

I authorise and request any person or medical institution (including, but not limited to, hospitals, doctors, nurses and other health professionals) who have provided me with medical advice or treatment in connection with this claim to provide reasonable information Freedom Health Insurance, or any authorised administrator acting on their behalf, may request in connection with that medical advice or treatment for the purpose of validating my claim.

I confirm I give consent, in accordance with current data protection legislation, and on behalf of myself and any family member named in this form, for Freedom Health Insurance, and any authorised administrator acting on their behalf, to process our personal information for the purposes of processing this claim. I have read and understood the data protection statement below.

Data protection statement

The personal and sensitive information (*'your data'*) you supply on this claim form will be used for the purposes of claims administration (including underwriting, assessing and processing claims payments, reinsurance and fraud investigation and prevention) by Freedom Health Insurance on behalf of the insurer.

Freedom Health Insurance may appoint a third party to assist with the administration of claims – for example, to place payment guarantees. Any third party appointed will only process data for the sole purpose of administering a claim and all processing carried out on behalf of Freedom Health Insurance is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by current data protection legislation.

Occasionally it may be necessary to process data outside of the European Economic Area (EEA) – for example, to guarantee payment of medical treatment costs. We will take all reasonable steps to ensure any organisation used to process data in these situations provides appropriate guarantees in respect of its technical and organisational security measures and the transfer and processing of data complies with all relevant data protection and privacy laws.

6. Signature

When you have completed all sections of the claim form, and read the declaration in section eight, please sign and date below. The policyholder named in section one must sign and date below for all claims.

Policyholder's signature:	Date:
Patient's signature (if different and the patient is 18 or over):	Date:

7. Where to send your completed claim form

By post: Freedom Worldwide claims department Freedom Health Insurance County Gates House, 300 Poole Road Poole, Dorset, BH12 1AZ United Kingdom	By email: intclaims@freedomhealthinsurance.co.uk Remember to send us clear and complete copies of all itemised invoices, receipts and medical reports. You do not need to send us the originals as well but please keep them safely for at least six months in case we ask to see them later.

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