الخليجية للتكافل
Gulf Takaful

الشركة الخليجية للتأمين التكافلي
Gulf Takaful Insurance Company
شركة خاضعة لأحكام الشريعة الإسلامية
الشرق ، شارع الشهداء – بناية التأمينات الاجتماعية سابقاً
تلفون : 1820202 فاكس : 22320243
e-mail : medical@gulftakaful.com

Authorized & Paid Capital K.D. 15,000,000 رأس المال المصرح به والمدفوع 15,000,000 د.ك
شركة خاضعة لأحكام قانون شركات ووكلاء التأمين رقم (24) لسنة 1961 رقم الإجازة (31)

MEDICAL INSURANCE SCHEME
DENTAL CLAIM FORM

Policy No. _____

PART 1

Patient's Membership No.

_____ **Policyholder :**

Group Member's Name (Mr./Mrs/Miss.)

_____ _____

Patient's Name (if not Group Member) Patient's date of birth

_____ _____

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

COMPLETE PART 1 OF THIS FORM :
Part 2 must be completed by the doctor / specialist giving details of treatment received. Submit this form with original account(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.

Is the cost of this treatment also covered by any other Insurer ?	Enter either YES or NO

Was the treatment necessary as the result of an accident ?	Enter either YES or NO

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

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 : .....

Medicines prescribed : .....

.....

Date :..... Signature of attending Doctor

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