MEMBER REIMBURSEMENT FORM

Please complete all sections of the form clearly and legibly.

GlobeMed
Gulf Healthcare Solutions L.L.C

Section 1 - Patient detail

Patient Card number: _____

Patient Name: _____

DOB: _____

Gender: Male

Principal Name: _____

Principal Card Number: _____

Section 2 - Medical information

(this section must be filled by the patient's treating physician/practitioner)

Presenting symptoms: _____

Date of onset of symptoms: _____

Diagnosis: _____

Treatment/Investigation: _____

I hereby affirm that I am the attending medical practitioner for the patient and that, to the best of my professional knowledge and belief, the particulars provided herein are true, accurate, and complete.

Physician name: _____

Physician signature & stamp: _____ Date: _____

Section 3 - Claim information

Treatment provider	Country of treatment	Date of treatment	Invoice date	Invoice reference	Amount (with currency)

Section 4 - Payment information

Settlement currency	**Settlement by:** ◉ Check ○ Wire Transfer
(A) Bank name	(B) Account holder Name: _____
(C) IBAN number / Account number	(D) SWIFT code: _____
(E) Bank address	(F) Beneficiary address: _____

Section 5 - Member's Declaration
(must be signed by the principal member or by the patient if aged 18 years old & above)

I hereby authorize GlobeMed Gulf to process, collect, store, record, use and/or disclose my confidential information, including personal and health data deemed necessary for:

a) Policy administration and claims processing;

b) Business development and product enhancement;

c) Enhancing customer experience;

d) Compliance with applicable laws, regulations, and industry standards;

e) Adherence to international sanctions and regulatory requirements. By providing this consent, I irrevocably and fully waive in favor of GlobeMed Gulf, my right of medical confidentiality related to all my past and current medical files and records and the files and records.

Name: _____

Signature: _____ **Date:** _____