SAICO
SAUDI ARABIAN INSURANCE CO.

# Claim Expense Form
# (Medical, Dental, Vision)

## A. EMPLOYEE'S SECTION

Member No.: _____ Employee No.: _____ Birth date: _____

Patient Name: _____ State Nature of Illness: _____

Country of Treatment: _____ Date of Treatment: _____

Date First Seen: _____

Pay to (Name): _____ Email address: _____

Currency: _____
*Customer reimbursement claims incurred in KSA or Abu Dhabi are only reimbursable by SAICO in local currency*

Bank Account No: _____ Bank Name: _____
(IBAN Number required for KSA Payments)

Mailing Address: _____

_____
(Settlement cheque will be deposited where possible or will be mailed to this address)

**Authorization**: I the undersigned, hereby certify that all answers and all documents submitted with this Claim form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or any information about me and/or any of my family members to provide SAICO with the complete information, including copies of their records with reference to any illness, accident, treatment, examination, advice or hospitalization. A photocopy of this authorization shall be taken as the original.

| **BREAKDOWN OF EXPENSES** (compulsory) | **CURRENCY**: | |
|---|---|---|
| Dr's FEES (consultation) | | |
| MEDICINES | | |
| OTHERS (lab, X-Rays, dental, vision, etc) | | |
| **TOTAL AMOUNT CLAIMED:** | | |

Member's signature: Date: Contact No.:

## B. PHYSICIAN'S SECTION

**Patient name (CAPITALS)**: _____ Age: _____

**Diagnosis (CAPITALS)**: _____ ICD: _____

Type of treatment: ☐ Illness Date first seen: _____

☐ Accident Work Related: ☐ YES ☐ NO Date: _____ Time: _____

Cause: _____ Place: _____

☐ Pregnancy Date of LMP: _____ Expected delivery date: _____

☐ Hospitalization Date admitted: _____ Date discharged: _____

**PHYSICIAN'S DECLARATION**: I certify that the Medical services shown on this form were medically indicated and necessary for the health of the patient.

Physician's Stamp: _____ Signature: _____ Date: _____

## C. ATTACHMENT'S REQUIRED

1. Invoices with proof of payment.
2. Doctor's prescription for medicines, lab tests, X-ray's etc.
3. Pharmacy invoice clearly showing name of medicine, quantity purchased and price of each medicine.
4. Copy of patient's SAICO membership card.

**Saudi Arabian Insurance Company (SAICO) – E-Mail: saicome@saicoins.com**
**Please reference your SAICO ID card for local phone and fax numbers.**