

Claim Form.

To help us provide you with a fast and efficient service, we kindly ask you to note the following:

- A fully completed form will speed up the assessment and payment of your claim
- All relevant original invoices must be attached. Unfortunately, photocopies, receipts and credit card slips cannot be accepted. We recommend that you keep copies of all documents submitted, should you require them at a later date
- A separate claim form is required for every patient and each medical condition
- **Finally, we kindly ask that you complete this form in BLOCK CAPITALS and post to the address below within 6 months after the end of the insurance year. Beyond this time we are not obliged to settle the claim**

1. Policyholder details.

Insurance number Title

Surname First name(s)

Correspondence address

Phone no. daytime Evening

Fax

Email

2. Patient details.

Title Surname First name(s)

Date of birth (dd/mm/yy) Is this claim related to an accident? Yes No

3. Payment details.

Option 1 Payment to Policyholder/Insured

Payment to be made in: Invoice currency Other currency (please specify)

Preferred payment method: Cheque Bank transfer (please fill in bank details)

Name of bank account

Account no./IBAN Sort/branch code

Swift code Bank name

Bank address

Option 2 Payment to Provider of Medical Service (e.g Hospital, Specialist, MRI)

Please tick if direct billing has been previously agreed with Allianz Worldwide Care

4. Patient signature and release of medical records.

I certify that to the best of my knowledge, this claim form does not contain any false, misleading or incomplete information. I understand that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for prosecution. In respect of any medical claim, I hereby authorise my medical practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Allianz Worldwide Care Limited or their appointed representatives. **If a minor was treated, a parent or guardian should sign this section.**

Patient signature Date (dd/mm/yy)

Sections 5 and 6 to be completed by treating doctor in BLOCK CAPITALS unless your invoices contain details of the diagnoses as well as the nature of your treatment.

5. Medical provider information.

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Phone Fax

Email

6. Medical information.

Has Treatment Guarantee been obtained? Yes No

Indicate type of treatment received: Elective Emergency

Indicate type of condition: Acute Chronic Acute episode of chronic

Please provide full details of the medical condition requiring treatment, including ICD code/DSM-IV

On what date did the patient first present these symptoms to you? Date (dd/mm/yy)

Prior to consulting you, when did the patient first notice signs or symptoms of this medical condition? Date (dd/mm/yy)

Are you aware of any treatment given for this or any related illness in the past? Yes No

If yes, please provide details

Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details

Name of referring physician

Telephone number

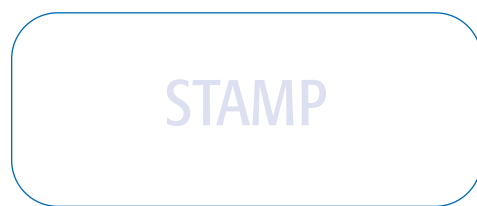
Date of referral

Applicable to dental treatment claims only.

Was the patient suffering from dental pain at the time he/she visited you for treatment? Yes No

Doctor signature

Date (dd/mm/yy)



The confidentiality of patient and member information is of paramount concern to Allianz Worldwide Care. Allianz Worldwide Care fully complies with European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date.