Claim Form

Please read the following carefully, completing all relevant information in **BLOCK CAPITALS** and ticking ☑ the relevant boxes

Important information – please read carefully.

To help us to process your claim in a timely manner, please follow the guidelines below:

- Please **check your Table of Benefits to ensure that you are covered for the expenses for which you are claiming** (if you are unsure what your policy covers, please contact our Helpline)
- To avoid delays to claims payment, **please complete all sections in full**, using **BLOCK CAPITALS**
- If you need to claim for expenses for the same condition in the future, simply photocopy the form. There is no need to complete the form again; however we may ask you to do this if the condition continues for more than 6 months
- **All relevant original invoices must be attached to the Claim Form** (photocopies and credit card slips cannot be accepted). We recommend that you keep copies of all documents submitted
- A separate Claim Form must be completed for every patient and each medical condition being claimed for
- Sections 1 to 5 should be completed by the member/claimant
- Sections 6 and 7 should be completed by the attending medical practitioner/specialist
- Claims should be submitted no later than 6 months after the end of each Insurance Year. If cover is cancelled during the Insurance Year, claims should be submitted no later than 6 months after the date that cover ceased. **Beyond this time we are not obliged to settle the claim**
- **If you have changed your contact details, please let us know on the Claim Form** so that we can update our records. To confirm which contact details we currently have for you, please contact our Helpline
- Please note that Claim Forms must be completed in English, German, French, Spanish or Italian

Please send your fully completed Claim Form(s) with original invoices attached, to the following address:
Claims Department, Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

Helpline

English:	+ 353 1 630 1301
German:	+ 353 1 630 1302
French:	+ 353 1 630 1303
Spanish:	+ 353 1 630 1304
Italian:	+ 353 1 630 1305
Fax:	+ 353 1 630 1306
Email:	client.services@allianzworldwidecare.com

Toll-free numbers

Toll-free from Singapore:	800 353 1018
Toll-free from Hong Kong:	800 901 705
Toll-free from North China:	10 800 744 1259
Toll-free from South China:	10 800 441 0115
Toll-free from the USA:	1 866 266 2182
Toll-free from France, Belgium and Switzerland:	00 800 66 302 302
Toll-free from Italy:	800 088 736

For your convenience, this form is available on our website www.allianzworldwidecare.com, along with a soft copy version which can be completed electronically, saved, and re-used as required. Once completed, the form simply needs to be printed and signed prior to submission.

Allianz Worldwide Care Limited, part of the Allianz Group, is registered in Ireland and regulated by the Irish Financial Services Regulatory Authority.
Registered Office: 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Registered No.: 310852

1 Policyholder's details.

Policy number

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other

First name

Surname

Date of birth d | d m | m y | y

Correspondence address

If this is a **new address**, do you want all future correspondence sent to this address? Yes ☐ No ☐

Telephone number (day time) COUNTRY CODE — AREA CODE —

Telephone number (evening) COUNTRY CODE — AREA CODE —

Fax COUNTRY CODE — AREA CODE —

Email

2 Patient's details.

Is the patient/claimant the policyholder stated above? Yes ☐ No ☐

If no, please provide patient/claimant details:

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other

First name

Surname

Date of birth d | d m | m y | y

3 Payment details.

Option 1: Payment to medical provider (e.g. hospital, specialist) ☐

Option 2: Payment to policyholder ☐

Preferred payment method: Cheque* ☐ Bank transfer** ☐

* Cheques payable to policyholders will be sent to the correspondence address provided in section 1 ** For bank transfer, please provide bank details below

Name of bank account holder as it appears on your bank statement e.g. John Smith

Please specify the currency you would like to be reimbursed in (and ensure that your bank account supports the currency chosen)

If your bank is **within the EU**, please supply **both** your IBAN and BIC/Swift code to guarantee the payment of your claim. If your bank is **outside the EU**, IBAN is not required.

Account number

IBAN (EU only)

Sort/branch code

BIC/Swift code

Name of bank

Bank address

Intermediary bank details (where applicable):

Name of intermediary bank

Swift code of intermediary bank

Intermediary account number

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 general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Allianz Worldwide Care or their appointed representatives.

If a minor was treated, a parent or guardian should sign this section.

Patient's signature Date d | d m | m y | y

5 Claim details.

In what country did the treatment take place?

Is this claim resulting from an accident or work-related illness/injury? Yes ☐ No ☐

If yes, please provide details

Do you hold any other insurance policy e.g. car insurance, which provides you with cover in relation to this accident/injury? Yes ☐ No ☐

If yes, please provide details of the insurer and your policy number

Are you filing a claim or lawsuit against a third party, including an insurance company, to recover costs incurred as a result of this accident/injury? Yes ☐ No ☐

If yes, please provide the details of third party concerned

Please complete all parts of the following table with the details of each invoice/receipt, making sure to include the amount and currency.

Description of expense	Provider's name	Amount charged	Currency	Has this bill been paid by you?

Sections 6 and 7 to be completed by treating doctor in BLOCK CAPITALS unless your invoices contain details of the diagnosis as well as the nature of your treatment.

6 Medical provider's details.

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Telephone number Fax

Email

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

Name of referring physician

Telephone number Date of referral d d m m y y

7 Medical details.

Indicate type of condition Acute ☐ Chronic ☐ Acute episode of chronic ☐

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

On what date did the patient first present these symptoms to you? d d m m y y

On what date would the first onset of symptoms have been apparent to the patient? d d m m y y

Has the patient suffered from this condition previously? Yes ☐ No ☐ If yes, when? d d m m y y

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

If yes, please provide details

Is it likely to re-occur? Yes ☐ No ☐

Does it need rehabilitation? Yes ☐ No ☐

Is it permanent? Yes ☐ No ☐

Does it need long term monitoring, consultations, check ups, examinations or tests? Yes ☐ No ☐

Pregnancy:

Estimated date of delivery d d m m y y

Is birth of a single baby expected? Yes ☐ No ☐

If you answered **No** to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes ☐ No ☐

If yes, please provide further details

Applicable to dental treatment claims only:

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

Please sign and authenticate with an official stamp.

Doctor's signature Date d d m m y y

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.

Official stamp of medical provider

Important - please check the following

- ☐ All original receipts, invoices and prescriptions are attached
- ☐ The Claim Form is completed in full
- ☐ The declarations are signed and dated
- ☐ The diagnosis has been confirmed and is either stated on the Claim Form or on the invoices