

Claim Form

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

Allianz 
Allianz Worldwide Care

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 either 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, Unit 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 from France, Belgium and Switzerland:	00 800 66 302 302
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 Singapore:	800 353 1018
Toll-free from Hong Kong:	800 901 705

www.allianzworldwidecare.com

For your convenience, there is a soft copy version of this Claim Form on our website which can be completed electronically, saved, and re-used if necessary. Once completed, the soft copy Claim Form can simply be printed and signed prior to submission.

1 Policyholder's Details.

Policy Number

Mr. Mrs. Ms Miss Other

First Name

Surname

Correspondence Address

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

Telephone (Day time) COUNTRY CODE — AREA CODE —

Telephone (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 not, 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, MRI)

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 / payee as it appears on your bank statement e.g. John Smith:

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

If your bank is within the EU, please supply your IBAN and Swift / BIC code to guarantee the payment of your claim.

Account Number

IBAN (E.U. only)

Sort / Branch Code

Swift / BIC 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 Limited 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

Sections 6 and 7 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.

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

Applicable to dental treatment claims only:

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

7 Medical Details.

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 of Diagnosis

How long prior to this date would the condition or symptoms been apparent to the patient?

Has the patient suffered from this condition previously? Yes No If yes, when?

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 (only needs to be completed in the event of twin or multiple pregnancies):

Is the pregnancy a result of infertility treatment, including conception by artificial means, other than artificial insemination? Yes No

If yes, please explain

Please sign and authenticate with an official stamp.

Doctor's Signature Date

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

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 attached