

Claim Form

Please complete this form in **BLOCK CAPITALS**. For your convenience, this form is available (editable PDF) on our website: www.agcs.allianz.com/global-offices/singapore/partnership-allianz-care.html

MyHealth app for quick and easy claims submission

www.allianzcare.com/en/myhealth.html



1	Policyholder's details													
	Policy Number													
	First name													
	Surname													
	Date of birth DD / MM / YYYY													
	Correspondence address													
	Telephone number COUNTRY AREA CODE CODE													
	Email													
	Do you have any national/public or state provided health insurance cover in your home country or country of residence e.g. National Health Insurance?													
	Yes □ No □													
	If Yes, please provide a description of the cover provided along with your reference number/identifier with the state.													
2	Patient's details (if different from policyholder) First name Surname Date of birth DD / MM / YYYYY Gender: Male DFemale													
3	Payment details													
	$\textbf{Option 1:} \ Payment to \ medical \ provider* (e.g. \ hospital, specialist) \\ \square \ (\text{The bank details requested below are not required for this option})$													
	Option 2: Payment to policyholder via bank transfer** □													
	Please specify the currency you would like to be reimbursed in (and ensure that your bank account supports it)													
	Name of bank account holder as shown on your bank statement													
	Account number													
	IBAN (where required)***													
	Sort/branch code BIC/Swift code***													
	Name of bank													
	Bank address													

- Swift code of intermediary bank (where applicable)

 * If you have not already paid the medical provider.
- ** For bank transfer, please provide bank details.
- *** If your bank is within the EU, or if your specific country requires an IBAN (e.g. Qatar, Saudi Arabia, Angola, Tunisia, Turkey), please supply both your IBAN and BIC/Swift code to facilitate the payment of your claim.

If you are aware of any additional information required in order to process international transactions within your country (e.g. Agency Code, Tax ID), please list below:

4 Claim details

5

Telephone number
Fax number
Email

Telephone number

Date of referral

Name of referring physician

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

Please complete all parts of the following table with the details of each invoice/receipt, making sure to include the amount charged. Please note that for costs incurred in China, a Fa Piao invoice needs to be submitted with all claims. If your invoice/receipt does not include the diagnosis/medical condition, please ensure that you provide us with this information below. If there is insufficient space in the table below, please provide details on a separate page.

Description of expense/treatment	Diagnosis,	medical conditi	on		Pi	ovider	's nam	e		Amo	unt cha	rged	Curi	rency		this bil id by y	
															Yes	□ N	o 🗆
															Yes	□ N	o 🗆
															Yes	□ N	o 🗆
															Yes	□ N	o 🗆
															Yes	□ N	o 🗆
															Yes	□ N	o 🗆
															Yes	□ N	o 🗆
	(Please note that th If you are	e total displayed is a claiming costs in dif				re issued	l in the so	ame curr	ency.								
what country did the treatment tak	e place?																
this claim is resulting from an accident or wor sts incurred as a result of this accident/injury,				nce pol	icy (e.g.	car ins	urance), or if y	ou are	e filing (a claim (or laws	uit agair	nst a thir	d party t	o reco	er the
Sections 5 and 6 are	e to be completed		eating receipt					led i	n th	e sup	port	ing d	locun	nenta	ition		
Medical provider's deta	ils																
ame of doctor/specialist																	
ualifications/credentials						4		Щ				<u> </u>				Щ	4
ame of hospital/clinic						+						11				<u> </u>	
ddress						+		Ш								Щ	4
			1 1 1								1 1	1 1			1 1		

6 Medical details Indicate type of condition: Acute Chronic Acute episode of chronic Please provide full details of the symptoms/medical condition requiring treatment, including ICD9/10 code/DSM-IV On what date did the patient first **present** these symptoms **to you**? On what date would the first onset of symptoms have 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□ Yes 🗆 No□ Is it permanent? Does it need long term monitoring, consultations, check ups, examinations or tests? Yes □ No□ Applicable to cases of pregnancy only: 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 🗆 Please sign and authenticate with an official stamp. Doctor's signature Date DD/MM//YYYY 7 We care about your personal data protection Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data and should be read by you before the submission of any personal data to us. To read our Data Protection Notice visit: www.agcs.allianz.com/footer/privacy-notice.html $If you have any queries about how we use your personal data, you can always contact us by e-mail at: {\bf AP.EU1DataPrivacyOfficer@allianz.com} \\$ Withdrawal of consent: you have the right to withdraw consent to the collection, use or disclosure of your personal data in accordance with the Personal Data Protection Act 2012. $\ \square$ Please tick to confirm I agree to the above data protection terms and conditions 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 contract will be cancelled from the date of discovery of the fraudulent event and I may be liable to prosecution. I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I authorise my medical practitioner, health professional or other relevant medical establishment to provide relevant medical information relating to me, if requested by the insurer, its medical advisers, its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply. If a minor was treated, a parent or guardian should sign and date this section. Date DD/MM/YYYY Patient's signature

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8 We need your consent

In line with the General Data Protection Regulation (GDPR), we need consent to process your medical information and pay your medical expenses. If you haven't provided us with your consent, please access my.allianzworldwidecare.com, login to Online Services and tick the required fields. Alternatively, you can download the Consent Form, available at www.allianzworldwidecare.com/en/consent-form/. A paper copy is available on request. Please note that every member on the policy over 18 needs to provide their own consent.

9 Third party authorisation

disclosure of sensitive r	medical inforn	mation.
	Date	D D / M M / Y Y Y
		Date

It is your responsibility to retain any original supporting documentation (e.g. medical receipts) where copies are submitted to us, as we reserve the right to request original supporting documentation/receipts up to 12 months after claim settlement, for auditing purposes. We also reserve the right to request a proof of payment by you (e.g. bank or credit card statement) in respect of your medical receipts. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that does not reach us for any reason that is outside of our reasonable control.

Please send your fully completed Claim Form(s) with any supporting invoices/receipts (credit card slips cannot be accepted) as follows:

Email to: claims@allianzworldwidecare.com

Fax to: + 353 1 645 4033

Post to: Claims Department, Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

If you have any queries, please contact our Helpline from inside Singapore: 1800 670 9766 or outside Singapore: +60 (0)3 92127818.

You can also send an email to: asia.helpline@allianz.com

For our latest list of toll-free numbers, please visit: www.allianzcare.com/toll-free-numbers



Did you know... that most of our members find that their queries are handled quicker when they call us?

IMPORTANT - PLEASE CHECK THE FOLLOWING:

All receipts, invoices and prescriptions are included.
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 invoice(s).

☐ If you have changed your contact details, please let us know on the Claim Form.

The insurer is Allianz Global Corporate & Specialty SE Singapore Branch, address 79 Robinson Road, #09-01 Singapore 068897. Company Registration No. T11FC0131K.