GlobalPass Healthcare Plans for Latin America

Claim Form

Please complete this form in **BLOCK CAPITALS**. For your convenience, this form is also available on our website: www.allianzworldwidecare.com/gpcf

1	Policyholder's details																					
	Policy Number														T	T	Т				\neg	
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	Surname								+			_	\pm	+	+	\pm	Н	Н		\equiv	\pm	
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	Correspondence address														T			_				_
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2	Patient's details (if different from policyho	lder)																				
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	First name				<u> </u>			+	<u> </u>	<u> </u>		<u> </u>	+	+	+	늗	L	닏	Ш	井	井	
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	Date of birth DD / MM / YYY Gender:		M	ale 🗆		FE	male	: Ш														
3	Payment details																					
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	Option 1: Payment to medical provider* (e.g. hospital, specialist) ☐ (The l	bank deta	ils reques	sted be	low ar	e not	requi	red fo	rthis	optio	n)											
	Option 2: Payment to policyholder □																					
	Payment under "Option 2" can only be made by cheque or bank wire trans			nolder																		
		Cheque*							_													
	Please specify the currency you would like to be reimbursed in (and ensure t Where we cannot reimburse in a local currency we will reimburse in US \$****	that your b	ank acco	unt su	pports	it)												Ш				
	Name of policyholder's bank account as shown on your bank statement															T	П				\Box	
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	Swift code of intermediary bank (where applicable)																					
	* If you have not already paid the medical provider.																					
	** For bank wire transfer, please provide bank details.																					

- Cheques payable to the policyholder will be sent to the correspondence address provided in section 1. If choosing payment by cheque, please note that in some countries you might need to advise your bank to release the cheque and transfer the money into your bank account.

 When you request a reimbursement for a claim in a foreign currency, we reserve the right to choose which currency exchange rate to apply.

 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.



4 Claim details

Please complete all parts of the following table with the details of each invoice/receipt, making sure to include the amount charged. 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 condition	Provider's name	Amount charged/ currency	Has this bill been paid by you?
				Yes □ No □
				Yes □ No □
				Yes □ No □
				Yes □ No □
				Yes □ No□
				Yes □ No □
				Yes □ No□
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				Yes □ No□
In what country did the treatment take place?				
Is this claim resulting from an accident or work-relati	ed illness/injury?	Yes No 🗆		
If yes, please provide details				

If this claim is resulting from an accident or work-related illness/injury and you hold any other insurance policy e.g. car insurance or if you are filing a claim or lawsuit against a third party to recover the costs incurred as a result of this accident/injury, please provide details in a separate document.

Medical provider's details Name of doctor/specialist Qualifications/credentials Name of hospital/clinic Address Telephone number Fax number 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 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? D D / M M / 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□ 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 🗆 No□ Does it need rehabilitation? Yes 🗆 Is it permanent? Yes 🗆 No 🗆 Does it need long term monitoring, consultations, check ups, examinations or tests? Yes □ No □ Applicable to cases of pregnancy only: Estimated date of delivery DD / MM M / YY 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 $\ \square$ Please sign and authenticate with an official stamp. Official stamp of medical provider

Doctor's signature

D D / M M / Y Y

FRM-ICF-Global-EN-0417

7 Data Protection and release of medical records

References to information includes personal information given by you to us, in your Application, Claim or Pre-Authorization Form and/or supporting documents/information we collect in connection with products or services we provide. Allianz Worldwide Care, part of the Allianz Group, is the data controller for this information.

Uses: Personal information may be used for insurance administration (e.g. underwriting, claims handling, fraud prevention). We may use third parties to process data on our behalf. Such processing, which may take place outside the European Economic Area (EEA), is subject to contractual restrictions regarding confidentiality and security in line with Data Protection obligations.

Sensitive data: We need to collect sensitive data relating to you (e.g. health details) to assess insurance terms and/or administer claims.

Disclosure: We may share your information with our agents, members of the Allianz Group, other insurers and their agents, service providers, and with any intermediary acting on your behalf or governing/regulatory bodies (of which we are a member or by which we are governed). In certain circumstances, we may use private investigators to investigate a claim you have submitted.

Retention: We are obliged to retain your records for six years from the date the insurance relationship ends. We will not retain your data for longer than is necessary and we will hold it only for the purposes for which it was obtained.

Representation and Consent: By signing this form you confirm that you have the authority to act on behalf of your dependents in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependents.

Access: You have the right to request and receive a copy of your personal data held by us. If you wish to do this, please write to the Data Protection Officer, at the address provided on this form or via client.services@allianzworldwidecare.com.

Call recording: Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes.

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 authorize my medical practitioner, health professional or other relevant medical establishment to provide relevant information relating to me, if requested by Allianz Worldwide Care, 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.

Patient's signature	Date	D D / M M / Y Y
Third party authorization		
As the claimant, I hereby authorize	ARTY	
to act on my behalf and on behalf of any dependents named on this form (where applicable), in relation to the administration of the	nis claim which i	may include the disclosure of
sensitive medical information.	no claim, milem	Thay include the disclosure of

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

By email to: claims@allianzworldwidecare.com

By fax to: + 353 1 645 4033

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By post to: Allianz Worldwide Care, 15 Joyce Way, Park West Buisness Campus, Nangor Road, Dublin 12, Ireland

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 fraud detection purposes. We also reserve the right to request proof of payment by you (e.g. bank or credit card statement) in respect of your medical receipts. In addition, we advise you to 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.

If you have any queries, please contact our Helpline on: + 353 1 630 1301 or email: client.services@allianzworldwidecare.com For our latest list of toll-free numbers, please visit: www.allianzworldwidecare.com/toll-free-numbers

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).
- $\hfill \square$ If you have changed your contact details, please let us know on the Claim Form.