

Claim Form

Please complete this form in **BLOCK CAPITALS**. You can also use our MyHealth Digital Services to submit your claim online:
www.allianzcare.com/en/myhealth.html

Don't forget: You must submit your claims within the claiming deadline set out in your Benefit Guide, available at:
www.allianzcare.com/egypt

1 Policyholder's details

Policy number

First name (and any middle name)

Surname

Date of birth / / ID number

Correspondence address

Telephone number COUNTRY CODE AREA 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 / / Gender: Male Female

3 Payment details

Please EITHER tick option 1 OR tick and complete option 2.

- Option 1:** Payment to medical provider* (e.g. hospital, specialist) (The bank details requested below are not required for this option)
- Option 2:** Payment to policyholder

Please note that payment will be made by 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

ABA/ACH code (for US bank accounts only)

Account beneficiary's address in the USA

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 it here:

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.

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. 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 condition	Provider's name	Amount charged	Currency	Have you paid this bill?
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
Total amount of expenses					
<small>(Please note that the total displayed is only accurate when all invoices are issued in the same currency. If you are claiming costs in different currencies, please disregard the total amount displayed)</small>					

In what country did the treatment take place?

Claims related to an accident or injury: Is this claim related to an accident/injury? Yes No

If yes, please complete the following:

Date of accident/injury / /

Details of the accident/injury

Do you have any other insurance policy (e.g. Travel insurance)? Yes No

If yes, please provide the following:

Name of the insurer

Policy number

Was the accident/injury caused by a third party? Yes No

If yes, please complete the following:

Name of the third party

Name of the third party insurer

Third party policy number

Please send us a copy of the police report if available to: claims.recoveries@allianzworldwidecare.com

5 Medical provider's details

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Telephone number COUNTRY CODE AREA CODE

Fax number COUNTRY CODE AREA CODE

Email

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

Name of referring doctor

Telephone number COUNTRY CODE AREA CODE

Date of referral / /

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

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

If twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction? Yes No

If Yes, please provide further details

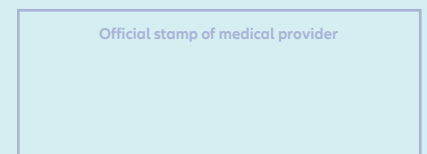
Applicable to dental treatment claims only:

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 / /



7 We care about your personal data protection

Our Data Protection Notice explains how we, Allianz Care, the administrators (data processors) acting on behalf of your insurer protect your privacy. This is an important notice which outlines how we will process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice visit: www.allianzcare.com/en/privacy.html

Alternatively, you can contact us on 19154 (when calling from inside Egypt) and on + 353 1 630 1301 (when calling from outside Egypt) to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by e-mail at: AP.EU1DataPrivacyOfficer@allianz.com

