

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

First name

Surname

Date of birth / /

Correspondence address

Telephone number Country code Area code

Email

2 Patient's details (if different from policyholder)

First name

Surname

Date of birth / /

Gender: Male Female

3 Payment details

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

Payment under "Option 2" can only be made by cheque or bank wire transfer to the policyholder.

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

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

Where we cannot reimburse in a local currency we will reimburse in US \$****

Name of policyholder's bank account as shown on your bank statement

Account number

IBAN (where required)*****

Sort/branch code Swift code*****

Name of bank

Bank address

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:

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.

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 physician

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 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 / /

Official stamp of medical provider

