

Treatment Guarantee 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 process the direct settlement of your medical expenses in a timely manner, please follow the guidelines below. If you have any questions, please contact our Helpline.

To the insured member/patient.

In order to ensure the swift guarantee of your treatment, please ensure that you complete sections 1 and 2. Please also ensure that your doctor completes all questions in section 3.

Failure to complete this form will delay our ability to guarantee your treatment with the medical provider, as we may have to revert to you or the medical provider for further information.

The insured member's policy must be in force at the time of treatment.

Please be advised that Guarantee of Payment is subject to the Terms and Conditions of the insurance policy as agreed between Allianz Worldwide Care and the insured member, and also subject to medical assessment of all relevant medical documentation received, or yet to be received, by Allianz Worldwide Care in respect of this medical condition.

Medical Services Department, Allianz Worldwide Care, Ground Floor, 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

Toll-free

Toll-free from Singapore: 800 353 1018
Toll-free from Hong Kong: 800 901 705
Toll-free from North China: 10 800 744 1259
Toll-free from South China: 10 800 441 0115
Toll-free from the United States: 1 866 266 2182
Toll-free from France, Belgium and Switzerland: 00 800 66 302 302

Fax: + 353 1 630 1306
Email: client.services@allianzworldwidecare.com

This form is available on our website www.allianzworldwidecare.com, along with a version which can be completed electronically, saved, and re-used as required (once completed, the form simply needs to be printed and signed prior to submission).

1 Insured Section.

To be fully completed by (or on behalf of) the patient.

Mr. Mrs. Ms Miss Other

First name

Surname

Date of birth

Policy number

Telephone number

Fax

Email

2 Patient Signature and Release of Medical Records.

I hereby authorize my medical 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 patient or guardian should sign this section.

Patient's Signature Date

