GROUP CLAIM Form

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

MyHealth app for quick and easy claims submission

www.allianzworldwidecare.com/myhealth

1 POLICYHOLDER'S DETAILS

International Policy Number Date of birth D D / M M / Y Y Y Y

First name

Surname

Latest 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 D D / M M / Y Y Y Y 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 ☐

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

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

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 transfer, please provide bank details. *** Cheques payable to the policyholder will be sent to the correspondence address provided in section 1.*
***** 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. Please note that for costs incurred in China, a FaPiao 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	Has this bill been paid by you?
			0.00		Yes ☐ No ☐
			0.00		Yes ☐ No ☐
			0.00		Yes ☐ No ☐
			0.00		Yes ☐ No ☐
			0.00		Yes ☐ No ☐
			0.00		Yes ☐ No ☐
			0.00		Yes ☐ No ☐
Total Amount of Expenses			0.00		

(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)

In what country did the treatment take place?

Applicable to cases of pregnancy only: Estimated date of delivery D D / M M / Y Y Y Y

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.

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Sections 5 and 6 are to be completed by the treating doctor unless detailed in the supporting documentation (e.g. receipts or invoices).

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 D D / M M / Y Y Y Y

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**? D D / M M / Y Y Y Y

On what date would the first onset of symptoms have been **apparent to the patient**? D D / M M / Y Y Y Y

Official stamp of medical provider

Please sign and authenticate with an official stamp.

Doctor's signature

Date D D / M M / Y Y Y Y

7 DATA PROTECTION AND RELEASE OF MEDICAL RECORDS

We are entitled to process the personal data of an insured person once he/she has been included in the insurance agreement. According to the Federal Law "On personal data" dated July 27th, 2006 N°152-FZ3 data can be processed for the following purposes: compliance with laws and other regulations related to personal data; performance of obligations under the insurance agreement, control of the quality of services rendered and/or protecting the insurer's interests.

The insurer guarantees that the insured persons' personal data to the insurer is performed only upon receipt of the Insured person's written consent in line with provisions of this article. Such consent will be effective within the whole period of insurance coverage and 5 years after its expiration or termination. Such consent may be withdrawn by an Insured person by giving the Insurer a written notice.

Processing of the Insured persons' personal data includes all activities listed in article 3 of the Federal Law dated July 27th, 2006 N°152-FZ «On personal data» (including all activities (operations) with personal data performed with or without use of automation facilities such as collecting, recording, systematization, accumulation, storage, specification (update, amendment), extraction, use, transfer (circulation, provision of access to) depersonalization, blocking, deletion of data). Along with this, the Insurer is entitled to transfer personal data to Allianz Group companies including cross-border transfer of personal data to AWP Health & Life Services Limited, a limited liability company registered in Ireland. Registered no.: 509216. Registered office 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Allianz Partners is a registered business name of AWP Health & Life Services Limited.

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.

Patient's signature Date D D / M M / Y Y Y Y

8 THIRD PARTY AUTHORISATION

As the claimant, I hereby authorise INSERT NAME OF THIRD PARTY to act on my behalf and on behalf of any dependants named on this form (where applicable), in relation to the administration of this claim which may include the disclosure of sensitive medical information.

Claimant's signature Date D D / M M / Y Y Y Y

Claimant's printed name

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 36 months after claims 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 invoices/receipts as follows:

By email to: claimsRU@allianzworldwidecare.com
by fax to: + 353 1 645 4033
or by post to: Claims Department, Allianz Partners, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

If you have any queries, please contact us:
+ 353 1 907 5951
client.servicesRU@allianzworldwidecare.com
For our latest list of toll-free numbers, please visit: www.allianzworldwidecare.com/toll-free-numbers

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

The insurer is LLC Insurance Company Allianz Life (LLC IC Allianz Life). Registered No. (OGRN): 1037727041483, address: 30 Ozerkovskaya nab, 115184 Moscow, Russia, phone:+7 (495) 232-0014, www.allianz.ru. Central Bank License: No. SL 3828, dated 28/09/2015. AWP Health & Life Services Limited, a limited liability company registered in Ireland, provides administration services and technical support for the policy. Registered no.: 509216. Registered office 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Allianz Partners is a registered business name of AWP Health & Life Services Limited.