

# Group 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/en/myhealth.html

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2	Claimant's details (if different from the patient in section 1)																																									
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	Please tick one of the options below and complete the details as needed.																																									
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Swift code of intermediary bank (where applicable)

<sup>\*</sup> If you have not already paid the medical provider.

<sup>\*\*</sup> For bank transfer, please provide bank details.

<sup>\*\*\*</sup> Cheques payable to the policyholder will be sent to the correspondence address provided in section 1.

## 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, you must submit a Fa Piao invoice. If your invoice/receipt does not include the diagnosis/medical condition, you must give 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 □ No □
					Yes □ No □
					Yes □ No □
					Yes □ No□
					Yes □ No □
	l displayed here is only accurate when all re claiming costs in different currencies, pl				
In what country did the treatment to	ake place?				
Applicable to cases of pregnancy of Estimated date of delivery	only:				
Claims related to an accident or inj	iury:				
Is this claim related to an accident/i	njury?	Yes □ No □			
If yes, please complete the following	g:				
Date of accident/injury	D / M M / Y Y Y				
Details of the accident/injury					
Do you have any other insurance po	olicy (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	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					

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

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

Medical provider's details
Name of doctor/specialist
Qualifications/credentials
Name of hospital/clinic
Address Address
Phone 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
Phone number COUNTRY CODE AREA CODE
Date of referral DD / MM / YYYY
Medical details
Indicate type of condition: Acute ☐ Chronic ☐ Acute episode of chronic ☐
Please provide full details of the symptoms or medical condition requiring treatment:
ICD9/10 code/DSM-IV
Details of the symptoms/medical condition
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?
Please sign and authenticate with an official stamp.
Official stamp of medical provider
Doctor's signature
Date
Your personal data
Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data. You should read it before submitting any personal data to us. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.
Alternatively, you can contact us on + 353 1 630 1301 to request a paper copy of our full Data Protection Notice. If you have any gueries about how we use your
personal data, you can always contact us by email at: AP.EU1DataPrivacyOfficer@allianz.com
Declaration
I certify that to the best of my knowledge, this Claim Form does not contain any false, misleading or incomplete information. I understand that if this claim is found to be fraudulent, in whole or in part, the contract will be cancelled from the date the fraud is discovered and I may be liable to prosecution.
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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 about me, if requested by Allianz Care, to its medical

advisers or its appointed representatives, or to any third-party expert(s) in case of disputes, subject to any legal restrictions which may apply.

Patient's signature

Date DD / MM / YYYY

If a minor was treated, a parent or guardian should sign and date this section.

5

6

7

8

#### 9 We need your consent

In line with the General Data Protection Regulation (GDPR), we need your consent to process your medical information and pay your medical expenses. If you have not yet provided us with your consent, please access my.allianzcare.com/myhealth/login, login to MyHealth Digital Services and tick the required fields. Alternatively, you can download the Consent Form from www.allianzcare.com/en/consent-form. A paper copy is available on request. Please note that every member on the policy over 18 must provide their own consent.

## 10 Third party authorisation

As the claimant, I authorise

NISERT NAME OF THIRD PARTY

to act on my behalf in relation to the administration of this claim. This may include the disclosure of sensitive medical information.

	Claimant's signature
Clair	mant's printed name
Date	

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It is your responsibility to retain any original supporting documents (e.g. medical receipts) when you send us copies, as we reserve the right to request original supporting documents up to 12 months after each claim has been settled, for auditing purposes. We also reserve the right to request a proof of your payment (e.g. bank or credit card statement) in respect of your medical receipts. 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.

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

© Email to:

claims@allianzworldwidecare.com

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Post to:

Claims Department,

Allianz Care, 15 Joyce Way, Park West Business Campus,

Nangor Road, Dublin 12, Ireland

## **Important** – please check the following:

- All receipts, invoices and prescriptions are attached
- The Claim Form is completed in full.
- The declarations are signed and dated.
- The diagnosis has been confirmed and is stated either on the Claim Form or on the invoices.
- If you have changed your contact details, please let us know on the Claim Form

#### Did you know...

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

If you have any queries, please contact our Helpline:

+ 353 1 630 1301 or email:

For our latest list of toll-free numbers, please visit:

client.services@e.allianz.com www.allianzcare.com/toll-free-numbers