

1 Policyholder's details

Policy Number First name

Claim Form

Please complete this form in **BLOCK CAPITALS**. For your convenience, this form is also available on our website:

Date of birth DD/MM/Y	YYY													
Correspondence address														
											П	T		
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Telephone number COUNTRY CODE		AREA CODE						T			Ħ	Ť	П	一
Email								Ħ	T	\equiv	Ħ	Ť	П	寸
Patient's details (if differ	ent from	policyhc	older)											
First name														
Surname														
Date of birth DD/MM/Y	YYY	Gende	r:	Male 🗌	Female l									
Payment details														
Option 1: Payment to medical provide	er* (e.g. hospit	al, specialist) 🗆	The bank det	ails requested be	elow are not re	quired for t	nis option)							
Option 2: Payment to policyholder ☐ ((Payment under "	'Option 2" can only	be made by che	eque or bank wir	e transfer to th	e policyhol	der)							
Preferred payment method: Bank	wire transfer*	** 🗌	Cheque***											
Please specify the currency you would	like to be rei r	nbursed in (and	l ensure that you	r bank account	supports it)									
Where we cannot reimburse in a local currency w	ve will reimburse i	in US \$****.												
Name of policyholders's bank account	as shown on	your bank stat	ement											
Account number														
IBAN (where required)*****											$\overline{}$		T = T	
Sort/branch code			BIC/Swift co	de****								<u> </u>	Ш	
Sort/branch code Name of bank			BIC/Swift co	de****										
· ·			BIC/Swift co	de****										
Name of bank	jA		BIC/Swift co	de*****										
Name of bank ABA code ACH (for US bank accounts only)			BIC/Swift co	de****										
Name of bank ABA code ACH (for US bank accounts only)	5A		BIC/Swift co	de****										
Name of bank ABA code ACH (for US bank accounts only) Account beneficiary's address in the US	5A		BIC/Swift co	de*****										
Name of bank ABA code ACH (for US bank accounts only)	5A		BIC/Swift co	de*****										
Name of bank ABA code ACH (for US bank accounts only) Account beneficiary's address in the US	5A		BIC/Swift co	de*****										
Name of bank ABA code ACH (for US bank accounts only) Account beneficiary's address in the US Bank address														
Name of bank ABA code ACH (for US bank accounts only) Account beneficiary's address in the US		red in order to p			actions with	in your c	ountry (a.g. Ager	ncy Cod	e, Tax IE)), ple	ase lis	st be	low:
Name of bank ABA code ACH (for US bank accounts only) Account beneficiary's address in the US Bank address If you are aware of any additional infor	rmation requir	red in order to			actions with	in your c	ountry (a	e.g. Ager	ancy Cod	e, Tax IE)), ple	ase list	st be	low:
Name of bank ABA code ACH (for US bank accounts only) Account beneficiary's address in the US Bank address	rmation requir	red in order to			actions with	iin your c	ountry (a	e.g. Ager	ancy Cod	e, Tax IE)), ple	ase lis	st be	low:

- 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.

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. 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

Description of expense/treatment	Dic	agnosis/m	edical (condit	ion			Pro	vider'	s nam	e		,	Amou	nt ch	arge	d	Cu	rrenc	zy .		s this oaid b		
																					Ye:	s 🗆	No) [
																					Yes	s 🗆	No) [
																					Yes	s 🗆	No) [
																					Yes	s 🗆	No) [
																					Yes	s 🗆	No	, [
																					Yes	s 🗆	No) [
																					Yes	s 🗆	No	, [
		ote that the to					all invo		issued	in the s	ame cu	urrency	٠.											
what country did the treatment take plac	e?																	Т						Т
nis claim resulting from an accident or wo	ork-relate	ed illnes	s/injur	y?				Yes		No														
es, please provide details																								
is claim is resulting from an accident or work-relate s incurred as a result of this accident/injury, please						nce pi	oolicy e	e.g. ca	r insur	ance (or if yo	ou are	e filing	g a clo	aim oi	r law	suit a	gains	t a th	nird p	arty t	o reco	over t	he
Sections 5 and 6 are to b	e comp	oleted		ie tr (e.g.						letai	iled	l in t	he	sup	por	ting	g do	cui	nei	nta	tion			

5 Medical provider's details

Name of doctor/specialist							
Qualifications/credentials							
Name of hospital/clinic							
Address							
	INTRY DDE	AREA CODE					
	INTRY DDE	AREA CODE					
Email							
Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details:							
Name of referring physician	n l						
	UNTRY DDE	AREA CODE					
Date of referral	D / M M / Y Y	YY					

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□ Yes □ No□ Is it permanent? Does it need long term monitoring, consultations, check ups, examinations or tests? Yes 🗌 No 🗆 Applicable to cases of pregnancy only: Estimated date of delivery $\ \square \ \square \ / \ M \ M \ / \ Y \ Y \ Y$ 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 Official stamp of medical provider Doctor's signature Date DD/MM/YYYY 7 Privacy Notice Allianz México, S.A. Insurance Company (hereinafter, "Allianz") with address located at Boulevard Manuel Ávila Camacho No. 164, Colonia Lomas de Barrilaco, Mayor's Office Miguel Hidalgo, C.P. 11010, in Mexico City, Mexico, will use your personal data collected here to: A) verify, confirm and validate your identity; B) evaluate your insurance application and risk selection or the circumstances to, where appropriate, enter into contracts with Allianz; C) comply with the obligations derived from the insurance contract that, where appropriate, is entered into; D) deliver all the documentation that is derived from the insurance contract that, where appropriate, is entered into; E) operate and monitor the insurance product requested or contracted with Allianz; and F) prevent and detect fraud and / or illegal operations. For more information about the treatment and the rights that you can assert, you can access the comprehensive privacy notice through our website: https://www. allianz.com.mx/aviso-de-privacidad (only available in Spanish). 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 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 authorize my medical practitioner, health professional or other relevant medical establishment to provide relevant information relating to me, if requested by Allianz Care and its affiliates and/or fronting Partner and their medical advisers, their 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. Date DD/MM/YYYY Patient's signature

9 We need your consent

We need consent to process your medical information and pay your medical expenses. If you haven't provided us with your consent, please access https://my.allianzcare.com/myhealth/1/login, login to Online Services and tick the required fields. A paper copy is available on request. Please note that every member on the policy over 18 needs to provide their own consent.

10 Third party authorization

As the claimant, I authorize	INSERT NAME OF THIRD PART	Υ
to act on my behalf and on the disclosure of sensitive m	this form (where applicable), in relation to the	e administration of this claim, which may include
Claimant's signature		Date DD/MM/YYYY
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 12 months after claim settlement, for fraud detection purposes. We also reserve the right to request proof of payment by you (e.g. bank or credit card statement) in respect of your medical receipts. In addition, 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 invoices/receipts (credit card slips cannot be accepted) as follows:

By email to: claims@allianzworldwidecare.com

By fax to: + 353 1 645 4033

By post to: Claims Department, Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

If you have any queries, Please contact our Helpline on: + 353 1 630 1301 or client.services@allianzworldwidecare.com For our latest list of toll-free numbers, please visit: www.allianzcare.com/en/pages/toll-free-numbers.html

Important - please check the following:

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