## **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

1 Policyholder's details

Latest correspondence address

Policy number Date of birth First name

Telephone number

Don't forget: You must submit your claims within the claiming deadline set out in your Benefit Guide, available at https://my.allianzcare.com/myhealth/login

Do you have any national/public or state provided health insurance cover in your home country of residence e.g. National Health Insurance?

Υ	es 🗆 No 🗆	]																																			
lf	If Yes, please name the cover provided. Please give your reference num						umbe	er/ic	denti	fier v	vith	the s	tat	e.																							
																															П	Т		Т	Т	Т	
				Ť	П		Ť	Ť	Ť	Ť	Ť			Ť	Ť	Ť	Ť													T	T	Ť	Ť	Ť	Ť	Ť	
									'	,																											
) F	Patient'	s details	: (if a	dif	fer	en <sup>.</sup>	t fr	on	าท	oli	cyl	റ	lde	r)																							
		Jactan	( ( (	<b>4</b> 111		C11		011	' P				Lac	1)																			_		_		
	irst name			+	Щ		+	+	+	+	+			4	4	+	+													ᆜ	4	4	+	4	4	4	
	urname			<u> </u>	Щ		4	_																						Ш	$\Box$	$\perp$		$\perp$	$\perp$		
D	ate of birth	D D /	ММ		Y	Υ	Y	Υ						Ger	nder			Mal	le L				Fen	nale	9 🔲												
3 F	Paymer	nt detail	S																																		
Р	lease EITHE	ER tick option	n 1 OR	tick	and	cor	nple	te o	ptio	n 2.																											
0	ption 1:	Payment to	medic	al n	rovic	der*	(e a	hos	nita	ılsn	ecia	list)	П					O	otic	n 2:	• Р	avn	nent	t to	noli	cyhi	olde	r $\square$									
Ŭ	•	The bank de												ptic	on.			O,	Jeic		. '	ayıı	ICII		poti	Cy i ii	otac										
Р	referred na	yment meth	nd.				Ba	nk tr	ans	fer*:	* 🗆			Che	20116	***	7																				
		fy the curren		MOI	ıld li'	ko tr						nd			1			acc	OUR	nt cii	nna	orte	i+)														
Ė	tease specif	y the current	cy you	T		NE II		Telli	IDUI	Jeu	T	I			iat y		T	. ucc	Oui	10.30	pp	) (3	11)							$\overline{}$		$\top$		$\overline{}$	$\overline{\top}$	$\top$	
N	lame of bar	nk account h	oldor o	nc ch	OWD	001	(OUT	han	k cto	aton	aont																										
		ik account n	older c	15 SI I	T	1011	your	Dan	K SU	len	Territ						T													$\neg$		$\neg$		_	$\top$	$\overline{}$	
^	.ccount num	har		+	Н		+	+	+	+	+			$\pm$		+	+													$\dashv$	$\dashv$	$\pm$	+	$\pm$	+	$\pm$	
				+	Н		+	+	+	+	+			$\pm$	_	+	+											_		井	+	+	+	$\pm$	$\pm$	+	
	BAN (where re			+	Н		+	+	+	+	+	1		DIG		· c .	1	tutut.										_		井	井	+	+	$\pm$	$\pm$	$\pm$	
	ort/branch			<u> </u>	Щ		_	+	+	<u> </u>	<u> </u>			BIC	./Swi	ift co	de*	***												ᆜ	_	4	4	+	+	+	
	lame of bar			<u> </u>	Щ		4	4	4	+	<u> </u>		Щ	4	_	4	<u> </u>	Ш												ᆜ	4	4	4	4	4	4	
В	ank addres	S		<u> </u>	Щ			4	<u> </u>	<u> </u>	<u> </u>			4		<u> </u>	<u> </u>													ᆜ	_	4	4	4	4	<u></u>	
					Щ									_																				<u>_</u>	_	<u> </u>	
																																		$\perp$			
Α	BA/ACH co	de (for US bo	ınk acc	coun	ts or	nly)																															
Α	ccount bene	eficiary´s add	dress in	the	USA	١.																															
lf	you are aw	are of any ac	ddition	al in	form	natic	n re	quire	ed ir	orc	der to	pr	ocess	inte	erna	tionc	al tro	ınsad	ctio	ns v	vithi	n yc	our	nuoc	ntry	(e.g	. ag	enc	у со	de, í	tax I	D), p	olea	se li	st b	elov	/:
																																T		T	T		
S	wift code of	intermediar	y bank	(wh	nere	app	licak	ole)		Ī				Ť	Ť	T	Ī													T	T	Ť	Ť	Ť	Ť	T	
*	If you have	not already po	id the m	nedico	al pro	vider				-							,																				

- 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, you must submit a FaPiao 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□
(Please note that the total displaye	d here is only accurate when all invoices a claiming costs in different currencies, pl	Total Amount of Expenses re issued in the same currency. If you are ease ignore the total amount displayed)			
In what country did the treatment to <b>Applicable to cases of pregnancy c</b>		D / M M / Y Y Y			
Claims related to an accident or inj If yes, please complete the following Date of accident/injury		ent/injury? Yes □ No □			
Details of the accident/injury					
Do you have any other insurance po		Yes □ No□			
If yes, please provide the following:  Name of the insurer					
Policy number					
Was the accident/injury caused by a		Yes □ No □			
If yes, please complete the following	g: 				
Name of the third party					
Name of the third party insurer					
Third party policy number					

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

5	Medical provider's details											
	Name of doctor/specialist											
	Qualifications/credentials											
	Name of hospital/clinic											
	Address 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 doctor											
	Telephone number COUNTRY CODE AREA CODE											
	Date of referral DD / MM / YYYYY											
6	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?											
	On what date would the hist oriset 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 DD/MM/YYYY											
7	We care about your personal data protection											
7	We care about your personal data protection											
7	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal											
7	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.											
7	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal											
7	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your											
	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by email at: AP.EU1DataPrivacyOfficer@allianz.com											
	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your											
	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by email at: AP.EU1DataPrivacyOfficer@allianz.com											
	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries 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.  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,											
	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries 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.  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											
	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries 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.  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.											
	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries 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.  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											
	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries 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.  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.											
	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries 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.  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.											
	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries 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.  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.											
	Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html.  Alternatively, you can contact us on +60 3 92127820 to request a paper copy of our full Data Protection Notice. If you have any queries 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.  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.											

# FRM-Indonesia-CF-GR-EN-1122

#### 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 https://my.allianzcare.com/myhealth/login, login 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 hereby authorise	INSERT 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	
Claimant's printed name	
Date	

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 invoices/receipts by:

Email to: claims@allianzworldwidecare.com

Fax to: + 353 1 645 4033

Post to: Claims Department, Allianz Care, 15 Joyce Way, Park West Business Campus,

Nangor Road, Dublin 12, Ireland

#### 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 on: +60 3 92127820 or email: asia.helpline@allianz.com. For our latest list of toll-free numbers, please visit: www.allianzcare.com/toll-free-numbers