Signature Healthcare Plans

Claim Form

Please complete this form in **BLOCK CAPITALS**. For your convenience, this form (PDF and editable Word version) is available on our website: www.allianzworldwidecare.com/ukmembers.

1 Policyholder's details

Policy Number

First name

Surname

Date of birth *(dd/mm/yy)*

Correspondence address

Telephone number *(Country code)* *(Area code)*

Email

2 **Patient's details** (if different from policyholder)

First name

Surname

Date of birth *(dd/mm/yy)* 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: Cheque** ☐ Bank transfer*** ☐

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 it appears 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.*

** *Cheques payable to the policyholder will be sent to the correspondence address provided in section 1.*

*** *For bank transfer, please provide bank details.*

**** *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.*

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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. Please note that for costs incurred in China, a Fa Piao 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?
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

In what country did the treatment take place?

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.

Applicable to dental treatment claims only:

Have you attended a dentist in the past 12 months and completed any treatment identified at that appointment? Yes ☐ No ☐

If Yes, please provide details

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 *(dd/mm/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/CCSD code

On what date did the patient first **present** these symptoms **to you**? *(dd/mm/yy)*

On what date would the first onset of symptoms have been **apparent to the patient**? *(dd/mm/yy)*

Has the patient suffered from this condition previously? Yes ☐ No ☐ If Yes, when? *(dd/mm/yy)*

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 ☐

Is it permanent? Yes ☐ No ☐

Does it need long term monitoring, consultations, check ups, examinations or tests? Yes ☐ No ☐

Applicable to cases of pregnancy only:

Estimated date of delivery *(dd/mm/yy)* 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/yy)*

7 Data Protection and release of medical records

Allianz Worldwide Care, a member of the Allianz Group, is an Irish authorised non-life insurance company and shall be the data controller in respect of all such information.

Uses: Information you supply may be used for the purposes of insurance administration (including underwriting, processing, claims handling, reinsurance and fraud prevention) by us. Allianz Worldwide Care may use third parties to process data on its behalf. Such processing, which may be undertaken outside the European Economic Area (EEA), is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

Sensitive data: We need to collect sensitive data relating to you (such as medical and health details) in order to assess the terms of insurance we issue/arrange or to administer claims which arise.

Retention: We are obliged to retain your records for six years from the date the insurance relationship ends. We will not retain your data for longer than is necessary and we will hold it only for the purposes for which it was obtained.

Consent: By providing us with your information, and by signing this Claim Form, you consent to all of your information being used, processed, disclosed and retained as set out above.

Representation: By your signature you warrant and represent to us that you have authority to act on behalf of your dependants in respect of all personal information you provide to us, you have the authority of your dependants to disclose this personal information for the uses listed above and you are consenting to the processing, disclosure, use and retention of your dependants information on their behalf. In these statements, all references to "you" or "your" shall be deemed to include both you and your dependants.

Access: You have the right to request and receive a copy of your personal data held by us. Should you wish to exercise this right, you should send the request in writing and address it to the Data Protection Officer, Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland, or by email to: client.services@allianzworldwidecare.com. A fee of €6.35 is chargeable under the terms of the Data Protection Acts and cheques should be made payable to Allianz Worldwide Care.

Call recording: Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes.

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.

In respect of any medical claim, I hereby authorise my general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Allianz Worldwide Care or their appointed representatives.

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

Patient's signature

Date *(dd/mm/yy)*

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

Scan and email to:	**claims@allianzworldwidecare.com**
Fax to:	**+ 353 1 645 4033** or
Post to:	**Claims Department, Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.**

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. In addition, 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.

If you have any queries, please contact our Helpline on: LoCall 0203 5642 546 (from within the UK) or on: +353 1 630 301 (from outside the UK). Alternatively, you can email us at: client.services@allianzworldwidecare.com.

For our latest list of toll-free numbers, please visit: www.allianzworldwidecare.com/toll-free-numbers

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.

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