CLAIM Form

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

POLICYHOLDER'S DETAILS								
Policy Number								
First name								
Surname								
Date of birth DD / MM / YYYY								
Correspondence address								
Telephone number CODE AREA CODE								
Email								
Do you have any national/public or state provided health insurance cover	er in your home country	or country of residence	ce e.g. National H	Health Insurance? Yes □ No □				
If Yes, please provide a description of the cover provided along with you	r reference number/ider	entifier with the state.						
PATIENT'S DETAILS (IF DIFFERENT FROM POLICYHO	OLDER)							
	OLDLIN							
First name								
Surname								
Date of birth $\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$	Male 🗆	Female 🗆						
Date of birth DD / MM / YYYY Gender:	Male 🗆	Female 🗆						
	Male 🗆	Female 🗆						
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- If you have not already paid the medical provider.
- ** For bank transfer, please provide bank details.

2

3

- *** 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, 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.

nease ensure that you provide us v	with this information below. If there	e is insufficient space in the table bel	ow, please provid	e aetails 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 □
		y accurate when all invoices are issued in the different currencies, please disregard the total			
n what country did the treatment tal					
	ork-related illness/injury and you hold any oth y, please provide details in a separate docum	er insurance policy (e.g. car insurance), or if you ent.	are filing a claim or lav	vsuit against a thi	rd party to recover the
Sections 5 and 6 c		ating doctor unless detailed in receipts or invoices).	the supporting	documenta	tion
MEDICAL PROVIDER'S DE	TAILS				
Name of doctor/specialist					
Qualifications/credentials					
Name of hospital/clinic					

Qualifications/credentials Name of hospital/clinic Address Image: Color of the color o

Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details:																						
Name of referring phys	sician																					
Telephone number	COUNTRY					AR	EA DF													П	T	

Date of referral		М	М	Υ	Υ	Υ	Υ

5

Email

MEDICAL DETAILS Indicate type of condition: Chronic Acute 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 🗌 If Yes, when? No Are you aware of any treatment given for this or any related illness in the past? Yes 🗌 No□ If Yes, please provide details Yes 🗌 No□ Is it likely to re-occur? 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: 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 🗆 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□ Official stamp of medical provider Please sign and authenticate with an official stamp. Doctor's signature Date DD/MM//YYYY WE CARE ABOUT YOUR PERSONAL DATA PROTECTION Our Data Protection Notice explains how we Allianz Care, the administrators (data processors) acting on behalf of your insurer, protect your privacy. This is an important notice which outlines how we will process your personal data and should be read by you before the submission of any personal data to us. To read our $Data\ Protection\ Notice\ visit:\ \textbf{www.allianzworldwidecare.com/en/privacy}.\ Alternatively,\ you\ can contact\ us\ on\ +961\ 5\ 422000\ (when\ calling\ from\ inside\ Lebanon)$ and on + 353 1 630 1301 (when calling from outside Lebanon) 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 e-mail at: AP.EU1DataPrivacyOfficer@allianz.com 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 Allianz SNA, 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

WE NEED YOUR CONSENT

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

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, which	ch may include the disclosure of sensitive medical information.
Claimant's signature	Date D D / M M / Y Y Y Y
Claimant's printed name	

PLEASE SEND YOUR FULLY COMPLETED CLAIM FORM(S) WITH INVOICES/RECEIPTS (CREDIT CARD SLIPS **CANNOT BE ACCEPTED) AS FOLLOWS:**

claims@allianzworldwidecare.com, By email to:

by fax to: + 353 1 645 4033.

or by post to: Claims Department, Allianz Care, 15 Joyce 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 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. 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 us:

+353 1 630 1301



client.services@allianzworldwidecare.com

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



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

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.

technical support for the policy. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.

The insurer of this policy is Allianz SNA s.a.l., registered in Lebanon in the Insurance Companies Register under No. 104, dated 3.23.1963 (as per decree No. 177/1 and subject to Legislative decree No. 9812 dated 5.4.1968 MOF 4698). Address:

Allianz SNA Building Hazmieh, P.O. Box 16-6528, Beirut, Lebanon. The policy is supported by AWP Health & Life SA, a limited company governed by the French Insurance Code and acting through its Irish Branch. AWP Health & Life SA is registered in France: No. 401 154 679 RCS Bobigny. The Irish Branch is

registered in the Irish Companies Registration Office with No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. AWP Health & Life SA acts as the reinsurer and provides administration services and