

Claim Form

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

1 Policyholder's details

Policy number	_____
First name	_____
Surname	_____
Date of birth	[D D] [M M] [Y Y]
Correspondence address	_____ _____ _____
Telephone number	[COUNTRY CODE] — [AREA CODE] — _____
Email	_____ _____

2 Patient's details (if different from policyholder)

First name	_____		
Surname	_____		
Date of birth	[D D] [M M] [Y Y]	Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>

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 shown 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. Saudi Arabia, Angola, Tunisia, Turkey), please supply both your IBAN and BIC/Swift code to guarantee the payment of your claim.

5 Medical provider's details

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Telephone number COUNTRY CODE — AREA CODE —

Fax 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 D | D M | M Y | Y

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 ICD code/DSM-IV

On what date did the patient first **present** these symptoms **to you**? D | D M | M Y | Y

On what date would the first onset of symptoms have been **apparent to the patient**? D | D M | M Y | Y

Has the patient suffered from this condition previously? Yes No If yes, when? D | D M | M Y | Y

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 D | D M | M 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.

Doctor's signature

Date D | D M | M Y | Y

Official stamp of medical provider

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 claims 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 6 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

Please send your fully completed Claim Form(s) with original invoices/receipts attached (photocopies and credit card slips cannot be accepted) to the following address:

Claims Department
Allianz Worldwide Care
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland

It is your responsibility 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.

**If you have any queries, please contact our Helpline on: + 353 1 630 1301
or email: 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:

- | | |
|--|--|
| <input type="checkbox"/> All original receipts, invoices and prescriptions are attached. | <input type="checkbox"/> The diagnosis has been confirmed and is either stated on the Claim Form or on the invoice(s). |
| <input type="checkbox"/> The Claim Form is completed in full. | <input type="checkbox"/> If you have changed your contact details, please let us know on the Claim Form. |
| <input type="checkbox"/> The declarations are signed and dated. | |