Claim Form

expatriate HEALTHCARE

Please ensure that all sections are completed in full and BLOCK CAPITALS.
Please note that the issuance of this claim form is in no way an admission of liability.

Section A - Claimant's Details

Certificate No:

Surname: First Name(s):

Address:

Home Tel: Mobile:

Fax: Date of Birth: Day Month Year

Email:

Would you like to receive general correspondence by email? YES NO

Do you hold any other medical insurance? YES NO

Insurer's Name: Policy No:

Insurer's Address:

Section B - Circumstances of the Claim

If you claiming for an accident Date occurred: Day Month Year

Where did the accident occur?

How did the accident occur?

Was a third party responsible? YES NO

Third party name: Tel:

Third Party Address:

If you claiming for an illness

Please describe symptoms suffered:

Date first noticed symptoms: Day Month Year

Have you ever suffered symptoms like this before the present episode? YES NO

If 'YES' please give dates: Day Month Year Day Month Year

Has the condition been diagnosed? YES NO

When was the condition diagnosed?

What is the diagnosis?

Have you seen any other doctor for advice/treatment of these symptoms? YES NO

If 'YES' provide contact details:

Please attach any additional details on a separate sheet

Section C - Amounts Claimed

Insured	Date	Name of Provider	Description of Service	Cost	Claimed Amount

If you cannot provide full details in the spaces above, please provide any additional information on a separate sheet.

Section D - Payment Details

Who would you like to be paid?

Primary Insured: ☐ Other: ☐

If 'Other'

Name:

Address:

How would you like to be paid?

Cheque: ☐ Bank Transfer: ☐

If 'Bank Transfer'

Bank Name:

A/C Holder's Name:

Bank Address:

Swift/Bank Routing No:

Account or IBAN No:

Currency in which you would like settlement:

Section E - Declaration & Permission

I declare that the information provided in this claim is, to the best of my knowledge, a fair and accurate reflection of the circumstance of my claim.

I understand that any misrepresentation will result in my cover being cancelled in full, without refund of premium. I understand that legal proceedings will be brought against me in the event of any proven fraudulent application for benefit.

Data Protection, Fraud Prevention and Detection

In order to administer your claim, this information will be used by Expatriate Healthcare, its appointed representatives and their group companies. It may be held on computer and or in manual files for administration and risk assessment purposes. We may disclose your personal data and sensitive data to, and may request information from other insurance companies for underwriting, claims handling and fraud prevention purposes. If you give us false or inaccurate information and we suspect fraud we will record this and pass this information to fraud prevention agencies.

By returning this form, you consent to our processing of your sensitive personal data for the above purposes. You also consent to our transferring of your information to countries which do not provide the same level of data protection as the UK, if necessary for the above purposes. If we do make such a transfer we will, if appropriate, put a contract in place to ensure your information is protected.

Where you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

Signed:

(If claimant is under 18, parent or guardian must sign)

Dated:

Section F - Access to Medical Reports

Before we can apply for a medical report from a Doctor who had cared for you, we need your consent by signing below. Before doing so, however, you should read this note carefully.

You do not have to give your consent but, if you do,you can say whether you wish to see the report before it is sent to us. If you do not give consent, this may affect our ability to assess your claim.

If you say you do not wish to see the report, we do not have to notify you if we apply for one. However, if, before such a report is sent to us, you change your mind, you can write to the Doctor saying you wish to see it, you will then have 21 days to contact the Doctor about arrangements for you to see the report.

If you say you wish to see the report, we will tell you at the same time as we write to the Doctor, and we will tell him you wish to see the report. You will then have 21 days to contact the Doctor about arrangements for you to see the report. Whether or not you say you wish to see the report before it is sent to us, the Doctor must let you see a copy for up to six months after it is supplied, if you ask. If you ask the Doctor for a copy of the report, he can charge you a reasonable fee to cover his costs.

Once you have seen a report before it is sent to us, the Doctor cannot submit it until he has your consent. You can write to the Doctor, asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your views on any part where you and the Doctor are not in agreement and which the Doctor is not prepared to alter.

The Doctor is not obliged to let you see any part of a report if, in his opinion that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the Doctor's intentions towards you, or if disclosure would be likely to reveal information about you, or the identity of another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional involved in caring for you.

In such cases, the Doctor must notify you and you will be limited to seeing any remaining part of the report. If it is the whole report, which is accepted, he must not send it to us unless you give your consent.

I do not wish to see any medical report ☐ I do wish to see the medical report ☐

Signed: _____ Dated: _____

(If claimant is under 18, parent or guardian must sign)

Section G - Medical/Dental Certificate WIRD VON IHREM (ZAHN-)ARZT AUSGEFÜLLT

(i) Patient's Details

Name des Patienten: _____ Geburts datum des Patienten: Tag Monat Jahr

Wann haben die Symptome eingesetzt? _____

Was sind die Symptome? _____

Datum der Diagnosestellung: Tag Monat Jahr

Wie lautet die Diagnose? _____

Grunderkrankung: _____

Sind diese Symptome bereits vorher aufgetreten? *(inkl. Begleiterscheinungen)* JA ☐ NEIN ☐

Daten der vorangegangenen Episoden: Tag Monat Jahr Tag Monat Jahr

Gibt es ergänzende Umstände, die diesen Zustand hervorrufen/dazu beitragen? JA ☐ NEIN ☐

Wenn ja, nennen Sie bitte Beispiele:

_____

_____

Seit wann sind Sie der behandelnde Arzt des Patienten/der Patientin? _____

Wenn weniger als 6 Monate, bitte Namen und Adresse des vorherigen Arztes angeben:

Name: _____

Adresse: _____

Bitte legen Sie zusätzliche Informationen als Anlage bei

Section G - Medical/Dental Certificate WIRD VON IHREM (ZAHN-)ARZT AUSGEFÜLLT

An welchem Datum konsultierte der Patient zum ersten Mal einen Allgemeinmediziner auf? Tag Monat Jahr

Detaillierte Angabe über die Behandlung:

Welche Medikamente wurden verschrieben:

Wie lange ist die voraussichtliche Behandlungsdauer?

Was ist die Prognose?

Bitte machen Sie genaue Angaben zum Diagnosetest *(und legen Sie die Resultate bei)*:

Wenn an Sie überwiesen, bitte geben Sie Name und Adresse des überweisenden Arztes an:

Name:

Adresse:

(ii) Schwangerschaft

Datum der letzten Periode: Tag Monat Jahr

Datum Bestätigung Schwangerschaft durch den Arzt: Tag Monat Jahr

Voraussichtliches Datum der Geburt: Tag Monat Jahr

Ist die Schwangerschaft das Resultat von künstlicher Befruchtung? JA NEIN

Hatte die Patientin bereits einmal einen Kaiserschnitt? JA NEIN

(iii) Zahnärztliche Angaben

Was war der Grund für die Konsultation?

Wenn durch Unfall entstandener Schaden, was hat ihn verursacht?

Zusammensetzung von Kronen/Füllungen: *(gegebenenfalls)*

(iv) Angaben Arzt/Zahnarzt

Voller Name:

Adresse:

Tel: Fax:

Email:

Unterschrift: Datum: Tag Monat Jahr

Offizieller Stempel:

Bitte fügen Sie zusätzliche Informationen/Details auf einem separaten Blatt bei

Section H - Important Notes

If this form is not completed in full, is illegible or does not have attached the necessary supporting documentation (original bills,etc) it will be returned to you which will result in delay. The cost for the completion of this form, or the provision of any additional information or documentation that we require to support your claim, is solely your responsibility.

Please note that all non-emergency in-patient treatment, day-patient treatment or claims in excess of €1,000 are required to be agreed by us in writing, before any treatment is received. This is to enable us to validate your claim before you incur changes and ensure that you don't receive any unexpected surprises after the fact.

Please ensure that:

You have attached all ORIGINAL medical bills and prescriptions		Sections A - E have been completed in full by YOU	
You have signed to agree to both Sections D and E		Your DOCTOR/DENTIST has completed and signed Section F	
Laboratory and Diagnostic reports are attached *(where applicable)*			
If you are claiming for Alternative Treatment or Physiotherapy, please attach a referral letter from your Specialist			

Please return the claim form, with all supporting material, to:

Expatriate Healthcare Claims Department
Third Floor
36-38 Botolph Lane
London
EC3R 8DE
United Kingdom

Section I - Parent's/Guardian's Details

Please complete this section if you are dealing with this claim on behalf of the claimant

Surname:		First Name(s):	
Correspondence Address:			
Home Tel:		Mobile:	
Fax:			
Email:			