Claim Form

Please read the following carefully, completing all relevant information in **BLOCK CAPITALS** and ticking ☑ the relevant boxes

Allianz
Allianz Worldwide Care

Important Information - Please read carefully.

To help us process your claim in a timely manner, please ensure you follow the guidelines below:

- **Check** your **Table of Benefits to ensure that you are covered** for the expenses you are claiming. If you are unsure what your policy covers, do not hesitate to contact our Helpline
- Claims payment will be delayed if all sections are not completed in full
- If you need to claim for expenses for the same condition in the future, photocopy the form and send with invoices / receipts. There is no need to complete the form again. We may however, request a new claim form if the condition continues for more than 6 months
- All relevant original invoices must be attached. Unfortunately, photocopies, receipts and credit card slips cannot be accepted. We recommend that you **keep copies of all documents submitted**, should you require them at a later date
- A separate Claim Form must be completed for every patient and each medical condition
- Sections 1 to 5 should be completed in full by the member / claimant
- Sections 6 and 7 should be completed by the attending medical practitioner / specialist
- Finally, we kindly ask that you complete this form in **BLOCK CAPITALS**
- Post to the address below within 6 months after the end of each insurance year or if cover is cancelled during the insurance year, within 6 months after the end of insurance cover. **Beyond this time we are not obliged to settle the claim**
- **If you have changed your address, please ensure that you let us know on the Claim Form and we can update our records. To confirm your address details held on our system, please contact our Helpline**

Claims Department, Allianz Worldwide Care, Unit 20D Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

Helpline	
English:	+ 353 1 630 1301
German:	+ 353 1 630 1302
French:	+ 353 1 630 1303
Spanish:	+ 353 1 630 1304
Italian:	+ 353 1 630 1305
Toll-free from France, Belgium and Switzerland:	00 800 66 302 302
Toll-free from mainland China:	10 800 441 0115
Toll-free from the USA:	1 866 266 2182
Toll-free from Singapore:	800 353 1018
Toll-free from Hong Kong:	800 901 705
Fax:	+ 353 1 630 1306
Email:	client.services@allianzworldwidecare.com

Additional Claim Forms are available to download from www.allianzworldwidecare.com

1 Policyholder's Details.

Policy Number

Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Other

First Name

Surname

Correspondence Address

If this is a **new address**, do you want all future correspondence sent to this address? Yes ☐ No ☐

Telephone Day COUNTRY CODE — AREA CODE —

Telephone Evening COUNTRY CODE — AREA CODE —

Fax COUNTRY CODE — AREA CODE —

Email

In what country did the treatment take place?

What is the currency of the invoice?

What is the total amount of the claim?

2 Patient's Details.

Complete if claimant / patient is not the policyholder.

Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Other

First Name

Surname

Date of Birth d d m m y y

Is this claim related to an accident? Yes ☐ No ☐

3 Payment Details.

To check payment details already on file, please contact the Helpline.

Option 1: Payment to Policyholder/Insured ☐

Please use payment details previously provided to Allianz Worldwide Care ☐

(It is advised that you confirm these first by contacting our Helpline)

Payment to be made in Invoice Currency ☐ Other Currency ☐ PLEASE SPECIFY OTHER CURRENCY

Preferred Payment Method: Cheque* ☐ Bank transfer** ☐

* Cheques payable to members will be sent to the correspondence address provided above | ** Please fill in bank details below if choosing payment by bank transfer

Name of Account Holder (as it appears on your bank statement):

If your bank is within the EU, please supply your IBAN and BIC/Swift code to guarantee the payment of your claim.

Account No./ IBAN

Sort/Branch Code

Swift / BIC Code

Name of Bank

Bank Address

Option 2: Payment to Provider of Medical Service (e.g Hospital, Specialist, MRI) ☐

Please tick if direct billing has been previously agreed with Allianz Worldwide Care ☐

4 Patient Signature and Release of Medical Records.

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 policy will be invalidated and I will be liable for 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 Limited or their appointed representatives.

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

Patient's Signature Date d d m m y y

5 Claim Details.

Please complete the following table with the details of each invoice / receipt

Description of Expense	Provider Name	Amount charged	Currency	Has this bill been paid by you?
Total Amount (please specify currency)				

Sections 6 and 7 to be completed by treating doctor in BLOCK CAPITALS unless your invoices contain details of the diagnoses as well as the nature of your treatment.

6 Medical Provider's Details.

Name of Doctor/Specialist

Qualifications/Credentials

Name of Hospital/Clinic

Address

Telephone Number Fax

Email

Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details

Name of Referring Physician

Telephone Number Date of Referral d d m m y y

Applicable to dental treatment claims only.

Was the patient suffering from dental pain at the time he/she visited you for treatment? Yes ☐ No ☐

7 Medical Details.

Indicate type of condition: Acute ☐ Chronic ☐ Acute episode of chronic ☐

Please provide full details of the medical condition requiring treatment, including ICD code/DSM-IV

On what date did the patient first present these symptoms to you? Date of Diagnosis d d m m y y

How long prior to this date would the condition or symptoms been apparent to the patient?

Has the patient suffered from this condition previously, if yes, when? Yes ☐ No ☐ 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 reoccur? Yes ☐ No ☐

Is it permanent, does it need rehabilitation? Yes ☐ No ☐

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

Pregnancy (only needs to be completed in the event of twin or multiple pregnancies).

Is your pregnancy a result of infertility treatment, including conception by artificial means, other than artificial insemination? Yes ☐ No ☐

If yes, please explain

Please sign and authenticate with an official stamp.

Doctor Signature Date d d m m y y

The confidentiality of patient and member information is of paramount concern to Allianz Worldwide Care. Allianz Worldwide Care fully complies with European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information, which you believe is inaccurate or out of date.

OFFICIAL STAMP

Important - please check the following

- ☐ All original receipts, invoices and prescriptions are attached
- ☐ 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 invoices