

GROUP CLAIM FORM

Please complete this form in **BLOCK CAPITALS**. You can also use our MyHealth Digital Services to submit your claim online: www.allianzcare.com/en/myhealth.html

! **Don't forget:** You must submit your claims within the claiming deadline set out in your Benefit Guide, available at <https://my.allianzcare.com/myhealth/login>

1 POLICYHOLDER'S DETAILS

Policy number

Date of birth / /

First name

Surname

Latest correspondence address

Telephone number COUNTRY CODE AREA CODE

Email

Do you have any national/public or state provided health insurance cover in your home country or country of residence e.g. National Health Insurance?
Yes No

If Yes, please name the cover provided. Please give your reference number/identifier with the state.

2 PATIENT'S DETAILS (IF DIFFERENT FROM POLICYHOLDER)

First name

Surname

Date of birth / / Gender: Male Female

3 PAYMENT DETAILS

Please EITHER tick option 1 OR tick and complete option 2.

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: Bank transfer** Cheque***

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

ABA/ACH code (for US bank accounts only)

Account beneficiary's address in the USA

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.

** For bank transfer, please provide bank details.

*** 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.

Please note that for costs incurred in China, you must submit a FaPiao invoice. If your invoice/receipt does not include the diagnosis/medical condition, you must give 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	Have you paid this bill?
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
					Yes <input type="checkbox"/> No <input type="checkbox"/>
Total Amount of Expenses					
(Please note that the total displayed here is only accurate when all invoices are issued in the same currency. If you are claiming costs in different currencies, please ignore the total amount displayed)					

In what country did the treatment take place?

Applicable to cases of pregnancy only: Estimated date of delivery / /

Claims related to an accident or injury: Is this claim related to an accident/injury? Yes No

If yes, please complete the following:

Date of accident/injury / /

Details of the accident/injury

Do you have any other insurance policy (e.g. Travel insurance)? Yes No

If yes, please provide the following:

Name of the insurer

Policy number

Was the accident/injury caused by a third party? Yes No

If yes, please complete the following:

Name of the third party insurer

Third party policy number

Please send us a copy of the police report if available to: claims.recoveries@allianzworldwidecare.com

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 doctor																																			
Telephone number	COUNTRY CODE				AREA CODE																														
Date of referral	D	D	/	M	M	/	Y	Y	Y	Y																									

6 MEDICAL DETAILS

Indicate type of condition: Acute Chronic Acute episode of chronic

Please provide full details of the symptoms or medical condition requiring treatment:

ICD9/10 code/DSM-IV

Details of the symptoms/medical condition

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?

Please sign and authenticate with an official stamp.

 Doctor's signature _____
Date

Official stamp of medical provider

7 WE CARE ABOUT YOUR PERSONAL DATA PROTECTION

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data. You should read it before submitting any personal data to us. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html


Alternatively, you can contact us on + 353 1 630 1301 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 email at: AP.EU1DataPrivacyOfficer@allianz.com

8 DECLARATION

I certify that to the best of my knowledge, this Claim Form does not contain any false, misleading or incomplete information. I understand that if this claim is found to be fraudulent, in whole or in part, the contract will be cancelled from the date the fraud is discovered 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 about me, if requested by Allianz Care, to its medical advisers or 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 _____
Date

