

# Group Claim Form

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



## Download our MyHealth app

Quick and easy claims submission

1. Provide a few key details
  2. Take a photo of your receipt(s)
- And you're done

[www.allianzworldwidecare.com/myhealth](http://www.allianzworldwidecare.com/myhealth)

## 1 Policyholder's details

Policy Number \_\_\_\_\_ Date of birth (dd/mm/yy) \_\_\_\_\_

First name \_\_\_\_\_

Surname \_\_\_\_\_

Latest correspondence address \_\_\_\_\_

Telephone number (incl. country code and area code) \_\_\_\_\_

Email \_\_\_\_\_

## 2 Patient's details (if different from policyholder)

First name \_\_\_\_\_

Surname \_\_\_\_\_

Date of birth (dd/mm/yy) \_\_\_\_\_ Gender: Male  Female

## 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: 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 \_\_\_\_\_

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, 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.

Description of expense/treatment	Diagnosis/medical condition	Provider's name	Amount charged/ currency	Has this bill been paid by you?
_____	_____	_____	_____	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"/>
_____	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

In what country did the treatment take place? \_\_\_\_\_

Applicable to cases of pregnancy only: Estimated date of delivery (dd/mm/yy) \_\_\_\_\_

If this claim is resulting from an accident or work-related illness/injury and you hold any other insurance policy (e.g. car insurance), or if you are filing a claim or lawsuit against a third party to recover the costs incurred as a result of this accident/injury, please provide details in a separate document.

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## 5 Medical provider's details

Name of doctor/specialist \_\_\_\_\_  
 Qualifications/credentials \_\_\_\_\_  
 Name of hospital/clinic \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone number (incl. country code and area code) \_\_\_\_\_  
 Fax number (incl. country code and area code) \_\_\_\_\_  
 Email \_\_\_\_\_  
**Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details:**  
 Name of referring physician \_\_\_\_\_  
 Telephone number (incl. country code and area code) \_\_\_\_\_ Date of referral (dd/mm/yy) \_\_\_\_\_

## 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 ICD9/10 code/DSM-IV \_\_\_\_\_  
 \_\_\_\_\_  
 On what date did the patient first **present** these symptoms to you? (dd/mm/yy) \_\_\_\_\_  
 On what date would the first onset of symptoms have been **apparent to the patient?** (dd/mm/yy) \_\_\_\_\_  
**Please sign and authenticate with an official stamp.**  
 Doctor's signature \_\_\_\_\_  
 Date (dd/mm/yy) \_\_\_\_\_

OFFICIAL STAMP OF MEDICAL PROVIDER

## 7 Data Protection and release of medical records

Allianz Worldwide Care, a member of the Allianz Group, is a French authorised 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 insurance 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.

**Disclosure:** We may share information which we hold about you and/or your claims history with our agents, members of the Allianz Group, other insurers and their agents, service providers, and with any intermediary acting on your behalf. We may also share this information with recognised, governing and regulatory bodies (of which we are a member or by which we are governed). In addition, we may, in certain circumstances, use private investigators to investigate a claim you have submitted.

**Retention:** We are obliged to retain your records for six 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, subject to legal restrictions in this regard.

I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of any medical records pertaining to my medical condition. I also authorise my medical practitioners, doctors, dentists, healthcare professionals, hospital employees and health services to communicate any relevant information relating to my medical condition to Allianz Worldwide Care's medical adviser(s) or to any third party expert(s) in case of disputes.

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

Patient's signature \_\_\_\_\_ Date (dd/mm/yy) \_\_\_\_\_

## 8 Third party authorisation

As the claimant, I hereby authorise \_\_\_\_\_ INSERT NAME OF THIRD PARTY \_\_\_\_\_  
 to act for and on my behalf in relation to the administration of this claim, which may include the disclosure of sensitive medical information.

Claimant's signature \_\_\_\_\_ Date (dd/mm/yy) \_\_\_\_\_  
 Claimant's printed name \_\_\_\_\_

*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 claims settlement for fraud detection purposes. 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.*

Please send your fully completed Claim Form(s) with invoices/receipts as follows:

By email to: [claims@allianzworldwidecare.com](mailto:claims@allianzworldwidecare.com), by fax to: + 353 1 645 4033, or by post to: Claims Department, Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.