Suisse International Healthcare Plans (VVG)

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.

1 POLICYHOLDER'S DETAILS

Policy number

Date of birth D D / M M / Y Y Y Y

First name

Surname

Country of residence

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 Y Y Gender: Male ☐ Female ☐

Country of treatment (if outside country of residence)

In what country did the treatment take place?

Duration of stay abroad

Reasons for stay abroad: ☐ Holidays ☐ Business trip ☐ Medical treatment

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 ☐

Payment method: 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

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.

*** 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.

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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 ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
		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)	0.00		

Applicable to cases of pregnancy only: Estimated date of delivery D D / M M / Y Y Y Y

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 D D / M M / Y Y Y Y

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

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

Sections 5 and 6 are to be completed by the treating doctor unless the information is detailed in the supporting documentation (e.g. receipts or invoices).

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**? D D / M M / Y Y Y Y

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

Please sign and authenticate with an official stamp.

Official stamp of medical provider

Doctor's signature

Date D D / M M / Y Y Y Y

7 DATA PROTECTION AND RELEASE OF MEDICAL RECORDS

The processing of personal data is essential to the transaction of insurance business. In the processing of personal data, we comply with the Swiss Data Protection Act (DPA). We store data electronically or physically in compliance with the applicable and relevant legal provisions.

References to information include personal information given by you to us, in your Application, Claim or Treatment Guarantee Form and/or supporting documents/information we collect in connection with products or services we provide.

Uses: The personal data processed by us include data relating to and for the purposes of preparing quotations, underwriting policies, collecting premium, paying claims and for any other purpose which is directly related to administering policies in accordance with the insurance. We may use third parties to process data on our behalf. Such processing, which may take place outside the European Economic Area (EEA), is subject to contractual restrictions regarding confidentiality and security in line with Data Protection obligations. We also process personal data in connection with product enhancements, as well as for our own marketing purposes. In order to offer affordable comprehensive insurance cover, our services may partly be provided by legally independent firms both domestically and abroad.

Sensitive data: We need to collect sensitive data relating to you (e.g. health details), to assess insurance terms and/or administer claims.

Disclosure: We may share your information with our agents, members of the Allianz Group, reinsurers, other insurers and their agents, previous domestic and foreign insurers, service providers, any intermediary acting on your behalf or governing/regulatory bodies (of which we are a member or by which we are governed). In certain circumstances, we may 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 necessary and will hold it only for the purposes for which it was obtained.

Representation and Consent: By signing this form you confirm that you have the authority to act on behalf of your dependants in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependants.

Access: You have the right in accordance with the DPA to request and receive a copy of your personal data held by us and may also request rectification of incorrect data. If you wish to do this, please write to the Data Protection Officer at the address provided on this form or via client.services@allianzworldwidecare.com

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 if this claim is found to be fraudulent, in whole or in part, the contract will be cancelled from the date and 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 my Insurer, 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 D D / M M / Y Y Y Y

8 THIRD PARTY AUTHORISATION

As the claimant, I hereby authorise _____ INSERT NAME OF THIRD PARTY

to act on my behalf and on behalf of any dependants named on this form (where applicable), in relation to the administration of this claim. This may include the disclosure of sensitive medical information.

Claimant's signature _____

Claimant's printed name _____

Date D D / M M / Y Y Y Y

It is your responsibility to retain any original supporting documents (e.g. medical receipts) when you send us copies, as we reserve the right to request original supporting documents up to 12 months after each claim has been settled, for auditing purposes. We also reserve the right to request a proof of your payment (e.g. bank or credit card statement) in respect of your medical receipts. We advise you 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.

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

Email to: claims@allianzworldwidecare.com

Fax to: + 353 1 645 4033

Post to: Claims Department, Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

Did you know...

...that most of our members find that their queries are handled quicker when they call us?

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.allianzcare.com/toll-free-numbers**