Suisse International Healthcare Plans

## Treatment Guarantee Form

For your convenience, this form (PDF version) is available on our website: www.allianz-assistance.ch/healthcare

Treatment Guarantee is not required in advance of emergency treatment, however either you, your physician, one of your dependants, or a colleague need to inform us about the hospital admission within 48 hours of the event.

Our Helpline (+ 353 1 630 1301) can take Treatment Guarantee details over the telephone if treatment is due to take place within 72 hours. Please have as many details as possible to hand when calling, including the contact details of your doctor.

Section 1	must be fully completed by (or on behalf of) the patien
Section 2	must be fully completed by the doctor

## PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS.

Failure to complete this form fully will delay our ability to guarantee your treatment as we may have to revert to you or the medical provider for further information. The patient's policy must be in force at the time of treatment. Please be advised that guarantee of payment is subject to the terms and conditions of the insurance policy and also subject to the assessment of all relevant documentation received, or yet to be received, by us in respect of this medical condition.

PATIENT DETAILS to be fully completed by (or on behalf of) the patient					
Policy Number					
Mr. Mrs. Ms. Miss Other  Surname	First name First name				
Date of birth DD / MM / YY					
bute of birth					
	should be contacted regarding the progress of this Treatment Guarantee request				
	should be contacted regarding the progress of this Treatment Guarantee request				
Contact person please specify who					
Contact person please specify who					
Contact person please specify who  Name Relationship to patient e.g. self, spouse/partner, p	parent				

## 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

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 includes 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

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.

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

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.

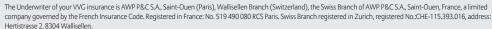
Access: You have the right in accordance with the DPA to request and receive a copy of your personal data held by us and may also request rectification of incorrect data. If you wish to do this, please write to the Data Protection Officer at the address provided on this form or via client.services@allianzworldwidecare.com.

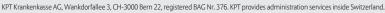
Call recording: Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes.

I 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 relating to me, if requested by my Insurer, its medical advisers, its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply.

Patient's signature







AWP Health & Life SA, acting through its Irish Branch, is a limited company governed by the French Insurance Code. Registered in France: No. 401 154 679 RCS Bobigny. Irish Branch registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. AWP Health & Life SA, acts as the reinsurer of the VVC policies, provides administration services and technical support outside Switzerland. Allianz Worldwide Care is a registered business name of AWP Health & Life SA.





## TREATMENT DETAILS to be fully completed by the Medical Provider

- If additional treatment is required, we must be notified.
- Please note that all invoices should be submitted within 60 days of patient discharge. Where special arrangements have been agreed between us and the medical provider, these arrangements will apply.

Condition					
Description of the condition, signs and symptoms					
Underlying cause (if known)					
Date this condition was first diagnosed DD / MM M / YY Date of first attendance for this condition DD / MM M / YY					
On what date would the first onset of symptoms have been apparent to the patient?					
Diagnosis (if unknown, please state provisional diagnosis)					
ICD9/10 DSM-IV DR	G				
Please also provide the following details for maternity cases					
Date pregnancy confirmed by doctor DD / MM M / Y Y Expected or actual date of delivery DD / MM M / Y Y					
Is birth of a single baby expected? Yes \( \sigma \) No \( \sigma \) If <b>No</b> , is the pregnancy a result	of medically assisted reproduction other than artificial insemination? Yes  \text{No }				
Delivery method Delivery method					
Treatment					
Planned procedure/treatment					
	Planned admission date DD / MM / YY				
For treatment in the USA/UK					
CPT code(s) CCSD code(s)					
Description					
Costs					
For treatment in Germany (DRG) please confirm Base Price (Basisfallpreis)					
Estimated length of stay night(s) \( \triangle \) (day(s) \( \triangle \) (tick as approp					
Is a package price being offered? Yes \( \) No \( \) If <b>Yes</b> , please state the price offered.					
If No, please provide a breakdown of estimated costs: Hospital charges  Total estimated costs incl. currency:	Physician/anaesthetist fees				
Total estimated costs incl. currency.					
Medical provider details					
Hospital/facility name					
Address (including country)					
Email (mandatory)					
Telephone (Country code) (Area code)					
Fax (mandatory) (Country code) (Area code)					
Referring physician	Attending/admitting physician				
Name	Name				
Email (mandatory)	Email (mandatory)				
Telephone (incl. country and area codes)	Telephone (incl. country and area codes)				
Fax (mandatory, incl. country and area codes)  Fax (mandatory, incl. country and area codes)					
Please sign, date and authenticate with an official stamp.					
I confirm that all the details given in this form are, to the best of my knowledge, true, accurate and complete.  Official stamp of medical providence of the details given in this form are, to the best of my knowledge, true, accurate and complete.					
Doctor's signature					
Date DD / MM / YY					
Please send this fully completed Treatment Guarantee Form at least five working days prior to treatment by:					

- Scan and email to: medical.services@allianzworldwidecare.com or
- Fax to: + 353 1 653 1780 or
- Post to: Medical Services Department, Allianz Worldwide Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. 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.