GlobalPass Healthcare Plans for Latin America

CLAIM FORM

Please complete this form in **BLOCK CAPITALS**. For your convenience, this form is also available on our website: www.allianzworldwidecare.com/gpcf

1 POLICYHOLDER'S DETAILS

Policy Number

First name

Surname

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

Correspondence address

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 ☐

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 ☐ (Payment under "Option 2" can only be made by cheque or bank wire transfer to the policyholder)

Preferred payment method: Bank wire transfer** ☐ Cheque*** ☐

Please **specify the currency** you would like to be **reimbursed** in (and ensure that your bank account supports it)
Where we cannot reimburse in a local currency we will reimburse in US $****.

Name of policyholders's bank account as shown on your bank statement

Account number

IBAN (where required)*****

Sort/branch code BIC/Swift code*****

Name of bank

ABA code ACH (for US bank accounts only)

Account beneficiary´s address in the USA

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 wire transfer, please provide bank details.*
*** *Cheques payable to the policyholder will be sent to the correspondence address provided in section 1. If choosing payment by cheque, please note that in some countries you might need to advise your bank to release the cheque and transfer the money into your bank account.*
**** *When you request a reimbursement for a claim in a foreign currency, we reserve the right to choose which currency exchange rate to apply.*
***** *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.*

Allianz Care

4 CLAIM DETAILS

Please complete all parts of the following table with the details of each invoice/receipt, making sure to include the amount charged. 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 ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐

Total amount of expenses
(Please note that the total displayed is only accurate when all invoices are issued in the same currency. If you are claiming costs in different currencies, please disregard the total amount displayed) 0.00

In what country did the treatment take place?

Is this claim resulting from an accident or work-related illness/injury? Yes ☐ No ☐

If yes, please provide details

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.

Sections 5 and 6 are to be completed by the treating doctor unless 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 physician

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/medical condition requiring treatment, including ICD9/10 code/DSM-IV

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

Has the patient suffered from this condition previously? Yes ☐ No ☐ If Yes, when? D D / M M / Y Y 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 re-occur? Yes ☐ No ☐

Does it need rehabilitation? Yes ☐ No ☐

Is it permanent? Yes ☐ No ☐

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

Applicable to cases of pregnancy only:

Estimated date of delivery D D / M M / Y Y Y Y Is birth of a single baby expected? Yes ☐ No ☐

If you answered **No** to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes ☐ No ☐

If Yes, please provide further details

Applicable to dental treatment claims only:

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

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 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 and should be read by you before the submission of any personal data to us. To read our Data Protection Notice visit: **www.allianzworldwidecare.com/en/privacy**

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 e-mail at: **AP.EU1DataPrivacyOfficer@allianz.com**

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 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.

I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I authorize my medical practitioner, health professional or other relevant medical establishment to provide relevant information relating to me, if requested by Allianz Care, 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.

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 WE NEED YOUR CONSENT

In line with the General Data Protection Regulation (GDPR), we need consent to process your medical information and pay your medical expenses. If you haven't provided us with your consent, please access **my.allianzworldwidecare.com**, login to Online Services and tick the required fields. Alternatively, you can download the Consent Form available at **www.allianzworldwidecare.com/en/consent-form/** and return it fully completed to us (details on the bottom of this form). A paper copy is available on request. Please note that every member on the policy over 18 needs to provide their own consent.

9 THIRD PARTY AUTHORISATION

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

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

Claimant's signature _____ Date D D / M M / Y Y Y Y

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 claim settlement, for fraud detection purposes. We also reserve the right to request proof of payment by you (e.g. bank or credit card statement) in respect of your medical receipts. In addition, 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 (CREDIT CARD SLIPS CANNOT BE ACCEPTED) AS FOLLOWS:

By email to: **claims@allianzworldwidecare.com**
By fax to: **+ 353 1 645 4033**
By post to: **Claims Department, Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.**

If you have any queries, Please contact our Helpline on: **+ 353 1 630 1301** or **client.services@allianzworldwidecare.com**
For our latest list of toll-free numbers, please visit: www.allianzworldwidecare.com/toll-free-numbers

IMPORTANT - PLEASE CHECK THE FOLLOWING:

- ☐ All receipts, invoices and prescriptions are included.
- ☐ 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 invoice(s).
- ☐ If you have changed your contact details, please let us know on the Claim Form.