Allianz Care

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**

1 Policyholder's details

Policy number

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

First name

Surname

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

To be completed by the insured person only during the first request for reimbursement or in the event of a change in bank details.

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)

* 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

To be completed only for members:

- who filled out a medical questionnaire upon affiliation.
- whose membership period is shorter than 24 months and if the medical claim relates to an illness or accident diagnosed before the cover start date.
- whose JSIS Statement does not specify the diagnosis.

Diagnosis/medical condition	Date of onset of symptoms	Amount charged/ currency	Amount reimbursed by the JSIS
	D D / M M / Y Y Y Y		
	D D / M M / Y Y Y Y		
	D D / M M / Y Y Y Y		
	D D / M M / Y Y Y Y		
	D D / M M / Y Y Y Y		
	D D / M M / Y Y Y Y		

In which country did the treatment take place?

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

5 We care about your personal data protection

Allianz Care complies with the Data Protection Regulation (GDPR) which came into force on May 25, 2018.

6 Declaration

I agree to provide Allianz Care, upon request, with any additional information or document enabling it to settle these costs correctly, it being understood that this information will be destroyed by Allianz Care as soon as the reimbursement has been made.

I certify that to the best of my knowledge, this Claim Form does not contain any false, misleading or incomplete information.

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

7 Third party authorisation

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

to act on my behalf in relation to the administration of this claim.

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 documentation (e.g. medical receipts) when you send us copies, as we reserve the right to request original supporting documentation up to 12 months after claim settlement, 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 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 us your completed reimbursement request* by:

Email: IGOclaims@allianzworldwidecare.com

Fax: +32 2 210 6598

Post: Claims Department, Allianz Care, Bd Roi Albert II 32, 1000 Brussels, Belgium

* Possibly accompanied by invoices/receipts for costs not listed (or not included) on the JSIS slip (only for certain services covered by Hospi Safe Plus)

Important – please check the following:

- ☐ You have included a copy of the reimbursement Statement made by the JSIS (if possible, specify the number of the slip).
- ☐ The Claim Form is completed in full.
- ☐ The declarations are signed and dated.
- ☐ Your contact details are still correct (if they have changed, please let us know on the Claim Form).

Our Helpline is at your disposal on **0800 70 528** (toll-free number from Belgium) or via e-mail at **igo.assistance@e.allianz.com**
For our latest list of toll-free numbers, please visit: **www.allianzcare.com/en/pages/toll-free-numbers.html**

The Underwriter of your insurance is AWP Health & Life SA, a limited company with a capital of €72,104,026 governed by the French Insurance Code, with its registered office at 7 rue Dora Maar, 93 400, Saint- Ouen, France. Registered in France: 401 154 679 RCS Bobigny. VAT number: FR 84 401 154 679. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.

The Administrator of your insurance is AWP Health & Life Services Limited – Belgium Branch having its branch trading address at Bd Roi Albert II 32, 1000 Brussels, Belgium. VAT: BE 0843.991.159. RPM Bruxelles: 843.991.159. Allianz Care and Allianz Partners are registered business names of AWP Health & Life Services Limited.

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