

# Claim Form

To help us provide you with a fast and efficient service, we kindly ask you to note the following:

- A fully completed form will speed up the assessment and payment of your claim.
- Please complete the front page of this form and ask your treating doctor to complete the back page.
- All relevant original invoices must be attached. Unfortunately, photocopies, receipts and credit card slips cannot be accepted.
- If you are submitting invoices from Germany or the USA, or if your invoices contain details of the diagnoses as well as the nature of your treatment, there is no need to complete the reverse side of this form, simply attach the original invoices.
- A separate claim form is required for every patient and each medical condition.
- We recommend that you keep copies of all documents submitted, should you require them at a later date.
- Finally, we kindly ask that you complete this form in block capitals and post to the address below.

## Policyholder Details

Insurance number  Title   
Surname  First name(s)   
Correspondence address   
  
Phone no. daytime  Evening   
Fax  E-mail

## Patient Details

Title  Surname  First name(s)   
Date of birth (dd/mm/yy)  /  /  Is this claim related to an accident? Yes  No

## Payment Details

**Option 1** Payment to **Policyholder/Insured**   
Payment to be made in: Invoice currency  Other currency (please specify)   
Preferred payment method: Cheque  Bank transfer  (please fill in bank details)  
Name of bank account   
Account no./IBAN  Sort/branch code   
Swift code  Bank name   
Bank address

**Option 2** Payment to **Provider of Medical Service** (e.g Hospital, Specialist, MRI)

Please tick if direct billing has been previously agreed with Allianz Worldwide Care

## Patient Signature & Release

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 policy will be invalidated and I will be liable for 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 Limited or their appointed representatives.  
**If a minor was treated, a parent or guardian should sign this section.**

Patient signature  Date (dd/mm/yy)  /  /

## To be completed by treating doctor in block capitals

## Medical Provider Information

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Phone  Fax

E-mail

## Medical Information

Has Treatment Guarantee been obtained? Yes  No

Indicate type of treatment received: Elective  Emergency

Please provide full details of the medical condition requiring treatment, including ICD code/DSM-IV

On what date did the patient first present these symptoms to you? Date (dd/mm/yy)

Prior to consulting you, when did the patient first notice signs or symptoms of this medical condition? Date (dd/mm/yy)

Are you aware of any treatment given for this or any related illness in the past? Yes  No

If yes, please provide details

**Applicable to dental treatment only.**

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

Doctor signature  Date (dd/mm/yy)

