# Claim Form

Please complete this form in **BLOCK CAPITALS.**

medmark TPA

## 1 Policyholder's details

Policy Number | Date of birth *(dd/mm/yy)*

First name

Surname

Latest correspondence address

Telephone number *(Country code)* *(Area code)*

Email

## 2 Patient's details (if different from policyholder)

First name

Surname

Date of birth *(dd/mm/yy)* | 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 ☐

Preferred payment method: Cheque** ☐ 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

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. ** Cheques payable to the policyholder will be sent to the correspondence address provided in section 1. *** 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.*

## 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, a Fa Piao invoice needs to be submitted with all claims. 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 ☐ |
| | | | | Yes ☐ No ☐ |
| | | | | Yes ☐ No ☐ |
| | | | | Yes ☐ No ☐ |

*Continued on next page*

## Claim details (continued)

In what country did the treatment take place?

**Applicable to cases of pregnancy only:** Estimated date of delivery *(dd/mm/yy)*

*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 *(dd/mm/yy)*

# 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**? *(dd/mm/yy)*

On what date would the first onset of symptoms have been **apparent to the patient**? *(dd/mm/yy)*

OFFICIAL STAMP OF MEDICAL PROVIDER

Please sign and authenticate with an official stamp.

Doctor's signature

Date *(dd/mm/yy)*

# 7 Data Protection and release of medical records

Allianz Worldwide Care Services, a member of the Allianz Group, shall be the data controller in respect of all such information.

**Uses:** Information you supply may be used for the purposes of insurance administration (including underwriting, processing, claims handling, reinsurance and fraud prevention) by us. Allianz Worldwide Care Services may use third parties to process data on its behalf. Such processing, which may be undertaken outside the European Economic Area (EEA), is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

**Disclosure:** We may share information which we hold about you and/or your claims history with our agents, members of the Allianz Group, other insurers and their agents, service providers, and with any intermediary acting on your behalf. We may also share the information with recognised, governing, and regulatory bodies (of which we are a member or by which we are governed). We may in certain circumstances use private investigators to investigate a claim you have submitted.

**Sensitive data:** We need to collect sensitive data relating to you (such as medical and health details) in order to assess the terms of insurance we issue/arrange or to administer claims which arise.

**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 is necessary and we will hold it only for the purposes for which it was obtained.

**Consent:** By providing us with your information, and by signing this Claim Form, you consent to all of your information being used, processed, disclosed and retained as set out above.

**Representation:** By your signature you warrant and represent to us that you have authority to act on behalf of your dependants in respect of all personal information you provide to us, you have the authority of your dependants to disclose this personal information for the uses listed above and you are consenting to the processing, disclosure, use and retention of your dependants information on their behalf. In these statements, all references to "you" or "your" shall be deemed to include both you and your dependants.

**Access:** You have the right to request and receive a copy of your personal data held by us. Should you wish to exercise this right, you should send the request in writing and address it to the Data Protection Officer, Allianz Worldwide Care Services, Place du Samedi 1, 1000 Brussels, Belgium, or by email to: IGOhelpline@allianzworldwidecare.com. A fee of €6.35 is chargeable under the terms of the Data Protection Acts and cheques should be made payable to Allianz Worldwide Care Services.

**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 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.

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 Services or their appointed representatives.

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

Patient's signature Date *(dd/mm/yy)*

*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. Claims should be submitted no later than six months after the date of treatment.*

**Please send your fully completed Claim Form(s) with original invoices/receipts to:**
MEDMARK: 44 Abdel Moneim Riad St., Mohandessin, Cairo, Egypt