

Claim Form

Please complete this form in **BLOCK CAPITALS**. For your convenience, this form (PDF and editable Word version) is available on our website: www.allianzworldwidecare.com/members.



Download our MyHealth app

Quick and easy claims submission

1. Provide a few key details
 2. Take a photo of your receipt(s)
- And you're done

www.allianzworldwidecare.com/myhealth

NAVIGATOR
Insurance Brokers Ltd.

Unit 8E, Golden Sun Centre, 223 Wing Lok St, Sheung Wan, Hong Kong
Tel : +852 2530 2530 | Fax : +852 2530 2535
Email : crew@navigator-insurance.com | www.navigator-insurance.com

1 Policyholder's details

Policy Number _____
First name _____
Surname _____
Date of birth (dd/mm/yy) _____
Correspondence address _____

Telephone number (incl. country code and 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: 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) _____

* If you have not already paid the medical provider.

** 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

Please complete all parts of the following table with the details of each invoice/receipt, making sure to include the amount charged. 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 <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
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				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>

In what country did the treatment take place?

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 (incl. country code and area code) _____
Fax number (incl. country code and area code) _____
Email _____

Applicable to **physiotherapy/psychotherapy** claims only. Please provide full referral details:

Name of referring physician _____
Telephone number (incl. country code and 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) _____

Has the patient suffered from this condition previously? Yes No If Yes, when? (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 _____

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 (dd/mm/yy) _____ 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.

Doctor's signature _____

Date (dd/mm/yy) _____

Official stamp of medical provider

7 Data Protection and release of medical records

Allianz Worldwide Care, a member of the Allianz Group, is a French authorised insurance company and 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 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.

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.

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 this information with recognised, governing and regulatory bodies (of which we are a member or by which we are governed). In addition, we may, in certain circumstances, use private investigators to investigate a claim you have submitted.

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.

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 or their appointed representatives, subject to legal restrictions in this regard.

I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of any medical records pertaining to my medical condition. I also authorise my medical practitioners, doctors, dentists, healthcare professionals, hospital employees and health services to communicate any relevant information relating to my medical condition to Allianz Worldwide Care's medical adviser(s) or to any third party expert(s) in case of disputes.

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

Patient's signature

Date (dd/mm/yy)

8 Third party authorisation

As the claimant, I hereby authorise

INSERT NAME OF THIRD PARTY

to act for and on my behalf in relation to the administration of this claim, which may include the disclosure of sensitive medical information.

Claimant's signature

Date (dd/mm/yy)

Claimant's printed name

Please send your fully completed Claim Form(s) with any supporting invoices/receipts (credit card slips cannot be accepted) as follows:

Scan and email to: claims@allianzworldwidecare.com

Fax to: + 353 1 645 4033 or

Post to: Claims Department, Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

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. In addition, 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.

If you have any queries, please contact our Helpline on: + 353 1 630 1301

or email: client.services@allianzworldwidecare.com

For our latest list of toll-free numbers, please visit: www.allianzworldwidecare.com/toll-free-numbers

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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.