GlobalPass Healthcare Plans for Latin America

Claim Form

Please complete this form in **BLOCK CAPITALS** in English, Spanish, Portuguese, German, French or Italian.

Allianz
Allianz Worldwide Care

1 Principal member's details

Contract number

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other

First name

Surname

Date of birth d d m m y y

Correspondence address

Telephone number COUNTRY CODE — AREA CODE —

Mobile telephone COUNTRY CODE — NETWORK CODE —

Email

2 Patient's details

To be fully completed by (or on behalf of) the patient.

Is the patient/claimant the principal member stated above? Yes ☐ No ☐ If no, please provide patient/claimant details:

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other

First name

Surname

Date of birth d d m m y y

3 Payment details

Option 1: Payment to medical provider (e.g. hospital, specialist) ☐ **Option 2:** Payment to principal member ☐

Payment can only be made by cheque or bank wire transfer in US$, to the principal member.

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

** Cheques payable to the principal member 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.*

*** If choosing payment by bank wire transfer, please fill in the following bank details:*

Full name of principal member's bank account (as it appears on bank statement e.g. John Smith):

Account number

Swift code

Name of bank

Bank address

Additional details

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):

4 Patient signature and release of medical records

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, intentionally exaggerated or if fraudulent means/devices have been used by me or my dependants or anyone acting on my or their behalf to obtain benefit under my contract, Allianz Worldwide Care will not pay any benefits for that claim. The amount of any claim settlement made under the contract, before the fraudulent act or omission was discovered, will become immediately due and owing to Allianz Worldwide Care. If the contract is rendered void due to false, fraudulent, intentionally exaggerated claims or if fraudulent means/devices have been used, premium will not be refunded, in part or in whole, and any pending claims settlements will be forfeited. In the event of fraudulent claims, 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 authorize my medical 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.

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

Patient's signature _____ Date d d m m y y

In order to process your claim, we may need to apply for a medical report. Please provide us with the patient's family doctor/general physician's contact details:

Name

Address

Telephone number COUNTRY CODE — AREA CODE —

Fax COUNTRY CODE — AREA CODE —

Email

5 Claim details

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

Do you hold any other contract e.g. motor, which provides you with cover in relation to this accident/injury? Yes ☐ No ☐

If yes, please provide details of the provider of that cover and your contract number

Are you filing a claim or lawsuit against a third party, including any provider of cover, to recover costs incurred as a result of this accident/injury? Yes ☐ No ☐

If yes, please provide the details of third party concerned

Please complete all parts of the following table with the details of each invoice/receipt, making sure to include the amount and currency.

Description of expense	Provider's name	Date	Amount charged	Currency	Has this bill been paid by you?

Sections 6 and 7 are to be completed by the treating doctor in BLOCK CAPITALS unless your invoices contain details of the diagnosis as well as the nature of your treatment.

6 Medical provider's details

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Telephone number Fax

Email

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

Name of referring physician

Telephone number Date of referral d d m m y y

7 Medical details

Indicate type of condition: Acute ☐ Chronic ☐ Acute episode of chronic ☐

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

On what date did the patient first present these symptoms to you? d d m m y y

On what date would the first onset of symptoms have been apparent to the patient? d d m m y y

Has the patient suffered from this condition previously? Yes ☐ No ☐ If yes, when? d d m m 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

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 d d m m y y

Official stamp of medical provider

8 Data Protection Acts – collection and use of personal information

In these statements, references to information include personal data and information given by you to us, whether in your application, any Claim Form and/or supporting documents or any information we may collect in connection with any product or service we provide. Allianz Worldwide Care, a member of the Allianz Group, is an Irish registered company and shall be the data controller in respect of all such information.

Uses: Information you supply may be used for the purposes of contract administration (including underwriting, processing, claims handling and fraud prevention) by us.

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

Retention: 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, 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: Under the Data Protection Acts 1988 and 2003, 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 Data Protection Officer, Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland, or by email to: client.services@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.

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

Patient's signature _____ Date d d m m y y

The confidentiality of patient and member information is of paramount concern to Allianz Worldwide Care. Allianz Worldwide Care fully complies with European Data Protection Legislation and International Medical Confidentiality Guidelines.

Please send your fully completed Claim Form(s) with original invoices attached (photocopies and credit card slips cannot be accepted) to the following address:

Allianz World wide Care
c/o Allianz Argentina
Av. Corrientes 299, piso 5
Cod Postal: C1043AAC
Buenos Aires
Argentina

Please contact our Helpline if you have any queries:
+ 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 original receipts, invoices and prescriptions are attached
- ☐ 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 invoices
- ☐ If you have changed your contact details, please let us know on the Claim Form