# Claim Form

## Completing the claim form

- Please complete clearly in block capitals
- Please use a separate sheet to provide full details if necessary

Please send claim form to:

Medilum
PT Global Asistensi Manajemen Indonesia (GAMI)
Plaza PP, 4th Floor
Jl. LETJEND TB. Simatupang no. 57
Pasar Rebo
Jakarta Timur 13760

Phone: +62 21 299 76300
Fax: +62 21 8778 5471
Email: expacare@medilum.com

## Section A - needs to be completed by the patient or patient's legal guardian

Insured person's/patients family name:

Insured person's/patients first name (s):

Nationality:

Date of Birth (DD/MM/YY):

Membership number:

Group name (if applicable):

Correspondence Address:

Is this a recent change of address: Yes ☐ No ☐

Telephone number:

Fax number:

Email address:

### Claim Details:

1) Is this **your** first claim for this medical condition? Yes ☐ No ☐

2) Are **you** claiming for cash **benefit**? Yes ☐ No ☐

3) Please describe the medical symptoms or event **you** wish to **claim** for:

4) Diagnosis *(if known)*:

5) Date you first noticed the symptoms?

6) Are **you** injured or ill as a result of an **accident**, (e.g. a road **accident** or an **accident** at work) or are **you** considering making a personal injury **claim** against someone else? Yes ☐ No ☐

7) Do **you** have any other insurance for this type of **claim**? Yes ☐ No ☐

8) Please list below the invoices for which you are claiming (Original invoices must be enclosed, not receipts or photocopies. We will keep these for audit purposes so please make copies for your records).

| Dates of **Treatment** | List of expenses for which **you** are claiming | Currency and amount paid | Who would **you** like **us** to pay | Preferred currency (***we** will do **our** best to oblige)* |
|---|---|---|---|---|
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Payment Details:

Bank transfers are the quickest and safest method of payment.
To enable **us** to pay the settlement directly into **your** account please give **us** the:

Account number*:

Account holder(s) names(s):

Bank code**:

SWIFT/BIC code:

IBAN number*:

Bank name:

Branch name:

Bank address:

Bank country:

* Please provide IBAN number for all bank accounts in EURO countries, for all other countries please provide a national account number

** Bank Codes are required in the following listed countries: Australia:BSB, Canada:CACPA, Denmark:BBC, Hong Kong: HKNCC, New Zealand: NZNCC, Singapore: IGB Sort Code, UK:SORT CODE, USA:ABA

## Section B - needs to be completed by the treating doctor/dentist

This section is only admissible if it is completed by the **specialist** or referring **doctor** who is registered and licensed to practice in the country where **you** receive **treatment**. **We** reserve the right to withhold **benefit** for **treatment** by **doctors** who do not hold internationally recognised qualifications and training (for example, a medical school listed in the World Health Organisation's World Directory of Medical Schools).

9) Please give description of symptoms:

10) Diagnosis:

11) The date of onset:

12) Please tell **us** when the patient first consulted a **doctor** for this or similar symptoms:

13) Has the patient received any **treatment**, had any need for **treatment** or required medication and/or advice for this condition in the past 2 years?
Yes ☐ No ☐

14) If the answer to Question 12 is yes, please provide details

15) To whom are **you** referring this patient? *(if applicable)*

Name:

Specialisation:

16) Date refered (DD/MM/YY):

17) What is the likely **treatment** plan and procedure to be performed?

18) If Medication has been prescribed, please provide details:

19) **Hospital** admission must be pre-authorised by **us**.

Name of **hospital**:

Proposed admission date:

Address of **hospital**:

Expected **hospital** stay *(if known length of stay)*:

20) Declaration:
I hereby certify that I am the patient's **doctor**.

Signature:

Date (DD/MM/YY):

Telephone number:

Fax number:

Email address:

Name and Address:

*Practice stamp*

## Dental claims

This section may only be completed by a **dentist** who is trained, qualified, and licensed to practice dentistry by the licencing authority of the country in which **you** receive **treatment**.

21) Please provide the dental history for the last 12 months?

22) Date of last routine check up and was any treatment carried out?

23) Start date of treatment

24) End Date of treatment

25) What **treatment** has been received by the patient?

26) Has all necessary **treatment** concluded?
If not please list planned **treatment**?

If this is a **claim** for restorative **treatment** after an **accident**, **we** will write to **you** requesting the information **we** need.

27) Signature of **dentist**:

Date (DD/MM/YY):

Telephone number:

Fax number:

Email address:

Name and Address:

*Practice stamp*

## Important Claim Information - please read

- **You** must get **our pre-authorisation** before making certain claims. Please refer to **your** membership guide
- **You** must send **us** the **claim** form within 6 months of the start of the **treatment**
- **We** recommend that **you** phone **us** before **you** start any **treatment**, so **we** can confirm the extent of **your** cover and help guide **you** through the claims
- Please complete a separate **claim** form annually for each unrelated medical condition and for each **insured person**
- Always send us original invoices (together with proof of payment) with this form. Photocopies, receipts and credit card statements will not be accepted.
- Where an **excess** or **co-insurance** applies **we** will deduct this from any settlement due and show the calculations in **our** letter to **you**
- Please provide **us** with **your** email address. This will reduce any delay in corresponding with **you** and also allow **us** to keep **you** updated with the progress of **your** claim

RELEASE OF MEDICAL INFORMATION

Expacare Limited (the "Company") together with its medical service and evacuation service suppliers ("Partners") needs your authority for release of medical information about you. In addition, in certain circumstances, we may be requested by your employer (where it meets the cost of your insurance) or to any insurance broker (lawfully appointed by you or your employer) to provide information about your claim. We always ensure that any information we supply to any third party is proportionate and relevant to the claim which we, as the insurance provider, are administering. We will not provide information which is not appropriate or relevant to the claim we are administering.

AUTHORISATION

I hereby authorise any doctor of medicine, hospital or other person who has attended or examined me, to furnish the Company and or its Partners, any and all information with respect to sickness or injury, medical history, consultation, prescriptions, or treatment and copies of all hospital and medical records. This information is required by the Company and its Partners in order to confirm coverage for my medical condition and proposed treatment. Further, I authorise and request that the Company provide such information to my employer (if appropriate) that is pertinent and relevant to its role as the policyholder that meets the premium for the insurance by which you are protected and to which the claim relates.

INSURED MEMBERS DECLARATION

I declare that to the best of my knowledge and belief, the information given on this form is true and complete. I understand and accept that in the event of this claim form being fraudulent in whole as or in part, the policy will be invalidated and I will be liable for prosecution.
I authorise and herewith agree that Expacare may forward data obtained from the claim form to the Insurer or its authorised Claims Administrator as the Insurance Company or any Reinsurer for the purpose of assessing the risk and handling the reinsurance.

I have read and understood the membership guide ☐
I have read and understood the important **claim** information ☐

From time to time **we** might feel it is important to contact **you** with reference to newsletters, new offerings etc. Please tick if **you** agree to receive such information. ☐

Signature: _____

Date (DD/MM/YY): _____

CHECKLIST:

| | |
|---|---|
| **Have you signed the Declaration?** | ☐ |
| **Have you completed Section A?** | ☐ |
| **Has your treating doctor/dentist completed and signed Section B?** | ☐ |
| **Have you enclosed itemised Invoices (together with proof of payment) for expenses that you are claiming for?** | ☐ |

ALL sections must be completed. Failure to do so will delay the assessment of your claim