

## Instructions - Please read carefully

- **Always contact us before receiving any of the following treatment:** (i) hospital admission (ii) PET, CT, MRI (iii) bone density, mammogram (iv) home nursing (v) psychiatric treatment (vi) genetic testing (vii) physiotherapy (viii) food intolerance test.
- Please complete in **BLOCK CAPITALS** throughout and **sign Section 5**. Use a separate form for each patient, treatment or medical condition.
- Claims for specialist consultations and any diagnostic procedures must be referred by your family doctor.
- Claim forms must be submitted within two months of treatment (online or by post), attaching bills or receipts and an itemised list of all tests carried out.
- We are unable to accept receipts where alterations have been made unless such alteration is signed by the person issuing the receipt.
- We reserve the right to ask for your previous medical history.

## 1. Patient Details

Please provide these details so that we can identify your policy	Title	<input type="text"/>	Full Name	<input type="text"/>	ID Card/Passport	<input type="text"/>
	Date of Birth	<input type="text"/>	DD/MM/YYYY	Policy Holder's ID Card/Passport	<input type="text"/>	where patient is under 18

Provide these if you are insured through a company	Group Name	<input type="text"/>	Employee Name	<input type="text"/>
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Update any details changed since you last claimed with us. If patient is under 18, provide policy holder details	Help us keep your data updated				
	Contact No	<input type="text"/>	Email	<input type="text"/>	Occupation
Address		<input type="text"/>			

## 2. Claim Details

Provide details about your claim. Please note for accidents we may request an accident report (ex: police report, injury report)	Amount being claimed	€ <input type="text"/>	Reason for seeking medical advice	<input type="text"/>
	Is this the first claim for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date patient first aware of symptoms	<input type="text"/>
	Is this claim the result of an accident?	<input type="checkbox"/> Motor related <input type="checkbox"/> Work related injury <input type="checkbox"/> Travel related illness or injury <input type="checkbox"/> Other		
	If yes, please give details	<input type="text"/>		
Is this claimable from any other source (i.e. another insurance company)?		<input type="checkbox"/> Yes <input type="checkbox"/> No		

## 3. Payment Instructions

Let us know how payment should be made	<input type="checkbox"/> Use Direct Credit details already on file <input type="checkbox"/> Use the details below for this and all future claims <input type="checkbox"/> Cheque against a bank & administration charge		
	SEPA IBAN	<input type="text"/>	
	Account Holder Name	<input type="text"/>	

### 4a. Medical Statement - To be completed by your General Practitioner

Name of patient	<input type="text"/>	Date of first consultation for this condition	<input type="text"/>
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Medical history of condition including details of previous episodes & treatment. Please indicate need for long term monitoring, consultation, check-ups or tests.

#### Treatment given

#### Family doctor declaration

I have examined the patient and I declare that I am unable to provide the necessary further treatment and I am therefore referring the patient to the following specialist

Family Doctor Signature and Stamp

Date

 DD/MM/YYYY

Telephone number

## 4b. Medical Statement - Specialist referred to by your General Practitioner

In cases of paediatrics or gynaecologist/obstetrics, the specialist must also complete part 4a.

If this section is not completed in full we may require a separate medical report

Name of patient	<input type="text"/>	State procedure code if known	<input type="text"/>
Details of condition	<input type="text"/>		
Drugs prescribed	<input type="text"/>		
Planned future treatment specifying any relevant dates	<input type="text"/>		
Diagnosis	<input type="text"/>		
Specialist Signature and Stamp	<input type="text"/>	Date	<input type="text" value="DD/MM/YYYY"/>
		Telephone number	<input type="text"/>

## 5. Declaration

### Data and Privacy Protection

Atlas Insurance PCC Limited and/or any other subsidiaries of Atlas Holdings Limited or any of its daughter companies (hereinafter 'Atlas', 'us', 'our', 'we') are the data controllers, as defined by relevant data protection laws and regulations, of personal data held about **you** or relating to **you** and/or to any other person/s whom **you** insure with **Atlas** (hereinafter 'others').

In completing all the forms related to **your** policies or claims, **you** confirm **your** understanding and acceptance of the terms in **our** Data Protection and Privacy Statement. **You** hereby warrant that **you** have informed **others** why **we** asked for this information and what **we** will use it for and have obtained the necessary explicit verbal consent to process such data for the purposes mentioned below.

**Atlas** collects and processes information about **you** and **others** for purposes which include preparing requested quotations, underwriting and administering the insurance proposal and **policy**, carrying out its contractual obligations including handling and settling of claims, and preventing or detecting crime (including fraud). **Atlas** may monitor calls to and from customers for training, quality and regulatory purposes.

**Atlas** may collect and disclose **your** and **others'** information from/to other entities in order to conduct **our** business including:

- managing claims, which may require **us** to obtain data including medical information from healthcare providers (including any public or private hospital, clinic, laboratory or other medical facility) and/or **your** employers (for company schemes) and which **you** hereby authorise to provide **us** with such information;
- administering policies with:
  - our** associated companies
  - introducers, intermediaries, agents or brokers when these are appointed by **you**,
  - the policyholder (in the case of corporate policies),
  - insurance principals, reinsurers and co-insurersincluding third parties providing services to these;
- helping **us** prevent or detect crime by sharing **your** information with regulatory and public bodies in **Malta** or, if applicable, overseas, including the police, as well as with other insurance companies (directly or via shared databases such as the Malta Insurance Fraud Platform), or other agencies or appointed experts to undertake credit reference or fraud searches or investigations;
- our** third party suppliers or service providers to whom **we** outsource certain business operations.

**We** will retain data for the period necessary to fulfil the above-mentioned purposes unless a longer retention period is required or permitted by law.

**You** can withdraw **your** consent to **Atlas** processing your personal information which is processed with your consent, e.g. direct marketing, at any time. **You** have the right to access **your** personal data and ask **Atlas** to update or correct the information held or delete such personal data from **our** records if it is no longer needed for the purposes indicated above. **You** may exercise these and other rights held in the **Atlas** Data Protection and Privacy Statement, by contacting **our** Data Protection Officer at The Data Protection Officer, Atlas Insurance PCC Limited, 48-50 Ta' Xbiex Seafront, Ta' Xbiex XBX 1021 Malta or email [dpo@atlas.com.mt](mailto:dpo@atlas.com.mt). Please note, however, that certain personal information may be exempt from such access, correction or erasure requests pursuant to applicable data protection laws or other laws and regulations.

If **you** and **others** consider that the processing of personal data by **Atlas** is not in compliance with data protection laws and regulations, **you** and **others** may lodge a complaint with **us** and/or the Office of the Information and Data Protection Commissioner by following this link <https://idpc.org.mt/en/Pages/contact/complaints.aspx>.

If **you** wish to view the full **Atlas** Data Protection and Privacy Statement, for a better understanding of how **we** use this data please visit <https://www.atlas.com.mt/legal/data-protection/>. Kindly note that this is subject to occasional changes including to comply with changing data protection laws, regulations and guidance.

Patient's signature (Policy holder to sign if patient is under 18)	<input type="text"/>	Date	<input type="text" value="DD/MM/YYYY"/>
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**I confirm my understanding and acceptance of the above**

*If submitted by post, we recommend that you photocopy the completed form and any enclosures for your records.*



For Internal use only

<input type="text"/>	<input type="text"/>
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Registered address: 47-50 Ta' Xbiex Sea Front Ta' Xbiex XBX 1021 Malta

Atlas Healthcare Insurance Agency Limited (C32603) is authorised under the Insurance Distribution Act to act as Enrolled Insurance Agents for Atlas Insurance PCC Limited (C5601) (AIPL). AIPL is a cell company authorised under the Insurance Business Act 1998 to carry on general insurance business. The non-cellular assets of the company may be used to meet losses incurred by the cells in excess of their assets. Both entities are regulated by the Malta Financial Services Authority.

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