

and Stamp

## **Health Claim Form**



## **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 Detail	s
Please provide these details so that we can identify your policy	Title Full Name ID Card/Passport  Date of Birth DD/MM/YYYY Policy Holder's ID Card/Passport where patient is under 18
Provide these if you are insured through a company	Group Name Employee Name
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 Email Occupation  Address
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 € Reason for seeking medical advice  Is this the first claim for this condition?  Yes No Date patient first aware of symptoms  Is this claim the result of an accident?  Motor related  Work related injury  Travel related illness or injury Other  If yes, please give details  Is this claimable from any other source (i.e. another insurance company)?  Yes No
3. Payment Insti	ructions
Let us know how payment should be made	Use Direct Credit details already on file Use the details below for this and all future claims Cheque against a bank & administration charge  SEPA IBAN  Account Holder Name  ement - To be completed by your General Practitioner
4a. Medicai Stat	
Name of patient  Date of first consultation for this condition  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	Date DD/MM/YYYY

Telephone number

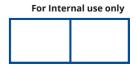
(Policy holder to sign if patient is under 18)



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.





Registered address: 48-50 Ta' Xbiex Sea Front Ta' Xbiex XBX 1021 Malta