Claim Form

Please send this form to Atlas Healthcare Insurance Agency Ltd – Abate Rigord Street, Ta' Xbiex XBX 1121, Malta within two months of treatment, attaching original bills or receipts and an **itemised list of all tests carried out. Please complete in BLOCK CAPITALS throughout.**

1. Subscriber and patient details

Policy number: Group (where applicable):

Title: Subscriber's name: ID/Passport number:

Address:

Title: Patient's name: ID/Passport number:

Date of birth: DDMMYYYY Relationship to subscriber: Occupation:

Contact Number: Email:

Reason for asking for medical advice:

Is this the first claim for this condition? Yes ☐ No ☐ Date patient first aware of symptoms: DDMMYYYY

Is this claim the result of any accident? Yes ☐ No ☐ If yes give details:

Is this claim claimable from any other source (ie another insurance company)? Yes ☐ No ☐

I declare that to the best of my knowledge and belief the statements made on this form are true and complete.

Data and Privacy Protection

Please make sure that you read this summary and the full data privacy notices on Atlas' and AXA's websites: https://www.atlas.com.mt/legal/data-protection/ or https://www.axapppphealthcare.co.uk/privacynotice.

AXA PPP healthcare limited (hereinafter referred to as 'we', 'us', 'our'), Atlas Healthcare Insurance Agency Limited (hereinafter referred to as 'Atlas') and/or any other subsidiary companies of Atlas Holdings Limited want to reassure you we never sell personal member information to third parties. We will only use your information in ways we are allowed to by law, which includes only collecting as much information as we need.

We and Atlas are the controllers of personal data held relating to you, under the terms of the Data Protection Act (hereinafter the 'Act'). In all forms that you complete in relation to this policy, you are deemed to accept the terms of this statement.

You hereby provide your explicit consent to allow

- us and Atlas to obtain information about you, or your minor dependents who are covered by your policy, from you, from your healthcare providers, hospitals and their associated companies, laboratories and other medical facilities, from your employer (if you are on a company scheme), from your insurance broker or intermediary if you have one, from other insurance providers, and from third party suppliers of information, such as credit reference agencies,
- healthcare providers, hospitals and their associated companies, laboratories and other medical facilities, or other health insurance providers to provide us or Atlas with full information in all forms of data and in whatever means in their possession, including past, present and future treatment including treatment which may or may not be insurable
- us or Atlas or a member of the Atlas Group to disclose your information to other people or organisations. For example to manage your claims, e.g. by dealing with your medical advisers; or to manage your policy with your insurance broker or intermediary; to help us prevent and detect crime and medical malpractice by talking to other insurers or to persons acting on their behalf and/ or instructions including (but not limited to) the Malta Insurance Association, to relevant agencies such as credit reference agencies, to the Malta Insurance Fraud Platform and other appointed experts together with the Commissioner of Police and any public or private hospital or clinic, other healthcare provider of any kind or any person, body or authority authorised by law to receive personal data; and allow other AXA companies possibly outside the EU and other subsidiaries or any daughter companies of Atlas Holdings Limited to contact you if you have agreed.
- us or Atlas to process your information mainly for the purpose of managing your membership, underwriting and settling of claims, including detecting, preventing and/ or suppressing and/or investigating fraud. We also have a legal obligation to report suspected crime to law enforcement agencies. This processing may be carried out by us or any other AXA companies possibly outside the EU, and/ or by Atlas or any other subsidiary companies of Atlas Holdings Limited (Atlas Group). We also process information to run our business, such as for research purposes, calculating premiums and marketing. We record and monitor calls for training, quality and regulatory purposes.

Where our using your information relies on your consent, you can withdraw it, but if you do, we may not be able to process your claims or manage your plan properly.

In some cases you have the right to ask us to stop processing your information or tell us that you do not want to receive certain information from us, such as marketing communications. You can also ask us for a copy of information we hold about you and ask us to correct information which you believe is inaccurate or out of date. You have the right to transfer your personal data to another Data Controller. If you want to ask to exercise any of your rights please write to the Data Protection Officer at the following address: The Data Protection Officer, Atlas Healthcare Insurance Agency Limited, Abate Rigord Street, Ta' Xbiex, XBX 1121, Malta, email: dpo@atlas.com.mt. Your request will be dealt with as soon as possible and in any case will not take more than 30 days to process.

Patient's signature: (Parent to sign if child is under 18) Date: DDMMYYYY

I confirm my understanding and acceptance of the above.

2. Your payment instructions

2.a Request for direct credit of payment to bank account (only requires completion ONCE for all future claims for this patient)

☐ I request ALL FUTURE CLAIMS to be paid directly to: Bank Branch

Bank account number (IBAN):

In the name of: BIC/SWIFT (Bank Identifier Code, foreign bank accounts only)

Please send notification of payment to the following email address:

☐ Please reverse my previous instructions to credit a bank account for claims in respect of this patient and issue cheques for this and any future claim payments.

Patient's signature if aged 18 or over (Subscriber's signature if patient is under 18): Date: DDMMYYYY

Note: Claim settlement by direct credit transfer is only possible for bank accounts which are within the Single Euro Payments Area (SEPA).

PB623339/04.18

2.b Request for payment to be made to a person other than the patient

Payments will otherwise ALWAYS be made directly to the patient whenever the patient is 18 and over.

I authorise benefit to be paid directly to:

Address:

Patient's signature if aged 18 or over
(Subscriber's signature if patient is under 18):

Date: DDMMYYYY

To help us assess your claim efficiently

Please follow these instructions carefully to ensure that your claim will be processed efficiently and without any need for further clarification.

1. Claims for specialist consultations and any diagnostic procedures must be referred by your family doctor.
2. Call Atlas Healthcare to confirm cover BEFORE:
   (i) being admitted to hospital even if only for a few hours (ii) a PET, CT or MRI scan (iii) a bone density scan (iv) a mammogram (v) home nursing (vi) psychiatric treatment. We will confirm the extent of your cover and put your mind at rest as to how your cover applies to the hospital or specialist you have chosen.
3. We recommend that you photocopy the completed form and any enclosures for your records.
4. We are unable to accept original receipts where alterations have been made unless such alteration is signed by the person issuing the receipt.

3. Medical statement

Part A – To be completed by your family doctor BEFORE your visit to the specialist

Date of first consultation for this condition: DDMMYYYY

Date patient first aware of symptoms: DDMMYYYY

Medical history of condition including details of previous treatment:

Treatment given:

Family doctor declaration
I have examined the patient on DDMMYYYY and I declare that I am unable to provide the necessary further treatment and I am therefore referring the patient to the following specialist:

Signature:

Date: DDMMYYYY

Stamp:

Telephone number:

Part B – To be completed by the specialist referred by your family doctor
In cases of paediatrics or gynaecology/obstetrics, the specialist must also complete part A.
If this section is not completed in full we may require a separate medical report

Name of patient:

State procedure code if known:

Details of condition:

Drugs prescribed:

Planned future treatment specifying any relevant dates:

Diagnosis:

Signature:

Date: DDMMYYYY

Stamp:

Telephone number:

Office Address: Abate Rigord Street Ta' Xbiex XBX 1121 Malta
Tel (356) 21 322 600 Fax (356) 23 265 601
Registered Office: 47-50 Ta' Xbiex Seafront Ta' Xbiex XBX 1021
Tel (356) 23 43 53 63 Fax (356) 21 344 666
Email: health@atlas.com.mt **Website:** www.atlas.com.mt

PB623339/04.18