Talent Trust

Medical Claim Form

Please type directly in this form, or write in **BLOCK CAPITALS**
Please submit a separate form for each family member and medical condition.
Please ensure claims are submitted within 90 days of treatment.
Please note that the issuance of this claim form is in no way an admission of liability.

1 Patient details

Policy ID

Date of birth DD / MM / YYYY

First name

Surname

Latest correspondence address

STATE

COUNTRY POST CODE

Phone number COUNTRY CODE AREA CODE

Email

Policyholder's name (if different from patient)

2 Circumstances of claim

If you are claiming for an accident.

Date occurred DD / MM / YYYY

Where did the accident occur?

How did the accident occur?

Was a third party involved in the accident? Yes ☐ No ☐

Third party's name

Third party's phone number

Third party's email address

If you are claiming for an illness.

Please describe symptoms suffered

Date first noticed symptoms DD / MM / YYYY

Have you ever suffered symptoms like this before the present episode? Yes ☐ No ☐

If 'Yes' please give dates DD / MM / YYYY
DD / MM / YYYY
DD / MM / YYYY

Has the condition been diagnosed? Yes ☐ No ☐

When was the condition diagnosed? DD / MM / YYYY

What is the diagnosis?

Have you seen any other doctor for advice/treatment of these symptoms? Yes ☐ No ☐

If 'Yes' provide your doctor's details:

Phone number COUNTRY CODE AREA CODE

Email

If you cannot provide full details in the spaces above, please provide any additional information on a separate sheet.

3 Amount Claimed

Treatment Date	Provider Name	Diagnosis	Treatment Provided (please state Inpatient, Day Patient, or Outpatient)	Currency	Claimed Amount

Treatment Date	Provider Name	Diagnosis	Treatment Provided (please state Inpatient, Day Patient, or Outpatient)	Currency	Claimed Amount

Bank details

Claim payment can only be made through bank transfer.

Please indicate your preferred payment currency (if none is selected the default currency is US Dollars)

The following information is required. Different country banking systems require different banking information. Please provide all relevant information for your bank location.

Name of bank account holder as shown on your bank statement

Account number

IBAN (where required)*

Sort/branch code

BIC/Swift code*

Name of bank

Bank address

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)

For US bank accounts please provide the following information.

ABA/ACH routing number code

Account beneficiary's address in the USA

* *If your bank is within the EU, or if your specific country requires an IBAN (e.g. Qatar, Saudi Arabia, Angola, Tunisia, Turkey), please supply both your IBAN and BIC/Swift code to facilitate the payment of your claim.*

5 Declaration & permission

I declare that the information provided in this claim is, to the best of my knowledge, a fair and accurate reflection of the circumstance of my claim.

I understand that any misrepresentation will result in my cover being cancelled in full, without refund of premium. I understand that legal proceedings will be brought against me in the event of any proven fraudulent application for benefit.

Data Protection, Fraud Prevention and Detection

n order to administer your claim, this information will be used by Talent Trust, its appointed representatives and their group companies. It may be held on computer and or in manual files for administration and risk assessment purposes. We may disclose your personal data and sensitive data to, and may request information from other insurance companies for underwriting, claims handling and fraud prevention purposes. If you give us false or inaccurate information and we suspect fraud we will record this and pass this information to fraud prevention agencies.

By returning this form, you consent to our processing of your sensitive personal data for the above purposes. You also consent to our transferring of your information to other countries, if necessary for the above purposes. If we do make such a transfer we will, if appropriate, put a contract in place to ensure your information is protected.

Where you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

For information on how we process your data, please see our **Data Protection and Privacy Policy**

Signature _____

Date DD / MM / YYYY

If claimant is under 18, parent or guardian must sign

6 Access to Medical Reports

I hereby authorize Talent Trust and its authorized representatives to obtain, access, and review my medical records and reports from any healthcare provider, hospital, clinic, or medical facility as may be necessary for the purposes of processing insurance claims, determining coverage eligibility, administering benefits, or other related insurance matters. This consent includes, but is not limited to, access to records regarding diagnosis, treatment, and any relevant medical history. I understand that this information will be kept confidential and used solely for the purpose stated above, in accordance with applicable privacy laws and regulations.

Signature _____

Date DD / MM / YYYY

If claimant is under 18, parent or guardian must sign

7 Medical/dental certificate

To be completed by the treating doctor unless the information is detailed in the supporting documentation (e.g. medical report, receipts or invoices).

Patient's Details

Patient's Name

Patient's Date of Birth DD / MM / YYYY

When was current episode first suffered? DD / MM / YYYY

What are the symptoms?

Date of diagnosed condition DD / MM / YYYY

What is the diagnosis?

Underlying cause

Has this previously been suffered from? (including associated conditions) Yes ☐ No ☐

Dates of previous episodes DD / MM / YYYY

DD / MM / YYYY

DD / MM / YYYY

Are there any contributing conditions that attribute/cause this condition? Yes ☐ No ☐

If yes please give details

How long have you been the patient's usual practitioner?

If less than 6 months, please provide name and address of previous practitioner:

Name

Address

What was the date the patient first consulted any medical practitioner? DD / MM / YYYY

Please detail the treatment

Please detail the medication prescribed

What is the likely treatment period?

What is the prognosis?

Please detail diagnostic test performed (and attach results)

If referred to you; please detail name and address of referring physician:

Name

Address

Pregnancy

Date pregnancy confirmed by Doctor DD / MM / YYYY

Expected due date DD / MM / YYYY

Was the pregnancy a result of assisted conception? Yes ☐ No ☐

Has the patient had a previous elective caesarean? Yes ☐ No ☐

Dental

What was the reason for the consultation?

If accidental damage; how was it caused?

Doctor/Dentist Details

Full Name

Address

Phone number

Email

Official stamp

Signature _____

Date DD / MM / YYYY

Please attach any additional details on a separate sheet.

8 Parent's/guardian's details

Please complete this section if you are dealing with this claim on behalf of the claimant.

First name(s)

Surname

Correspondence address

STATE

COUNTRY

POST CODE

Phone number

COUNTRY CODE

AREA CODE

Email

Please submit your fully completed Claim Form(s), along with all relevant invoices and receipts, to:

claims@talent-trust.com

If you have any questions, feel free to contact our 24/7 Helpline: **+1 800 495 5099**
** This number is toll-free in the US and is accessible for free via Viber.*

Medical Claim Form Check List

Before submitting your claim, make sure you've included everything!

Have you provided?

- ☐ Patient's details - Policy ID, name, contact number, and email
- ☐ Main policyholder's name - if different from the patient)
- ☐ Claim information - Date symptoms started, treatment dates, diagnosis/reason for visit, and claimed amount
- ☐ Bank account details - for claim reimbursement
- ☐ Signature - for signed consent & permission

Have you attached?

- ☐ Itemized bills/invoices
- ☐ Official receipt or proof of payment
- ☐ Prescription letter from your doctor (for medications)
- ☐ Doctor's referral letter - Required for physiotherapy, psychiatric treatment, etc.)
- ☐ Separate claim form - if submitting claims for multiple medical conditions