Talent Trust

Pre-authorization Form

Please type directly in this form, or write in **BLOCK CAPITALS**

- **Section 1:** To be completed by the patient or their representative.
- **Section 2:** To be completed by the attending doctor.
- Please allow up to 5 business days for review and approval of planned treatments. Emergency requests are typically processed within 12-24 hours.

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)

Contact person: please specify who we should contact regarding the progress of this Pre-authorisation request.

Name

Relationship to patient (e.g. self, spouse/partner, parent)

Phone number COUNTRY CODE AREA CODE

Email

2 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

3 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

4 Treatment details

To be fully completed by the medical provider.

Medical provider details

Hospital/facility name		
Address (including country)		
Email (mandatory)		
Phone (incl. country and area codes)		

	Treating/Attending Doctor	Referring Doctor
Name		
Email (mandatory)		
Phone (incl. country and area codes)		

Medical information

Is this a chronic condition? Yes ☐ No ☐

Description of the condition, signs and symptoms

Underlying cause (if known)

Date of first consultation DD / MM / YYYY

Date symptoms began DD / MM / YYYY

Has the patient experienced this or a similar condition before? (If yes, please attach details) Yes ☐ No ☐

Recommended treatment/procedure

Current medications

Admit as: In-patient ☐ Day patient ☐ Out-patient ☐

Preferred admission date DD / MM / YYYY

Expected length of stay

Room type: Private ☐ Semi-private ☐ Ward ☐

Please attach any medical report or doctor letter provided by your provider (if any).

For maternity case

Expected or actual date of delivery DD / MM / YYYY

Is the pregnancy a result of medically assisted reproduction? Yes ☐ No ☐

Delivery method:

Vaginal ☐ Cesarean ☐ Others (please specify)

Estimated Cost

Hospital charges	Doctor/anaesthetist fees	Total estimated costs incl. currency

Please attach the quotation provided by your provider (if any)

Please sign, date and authenticate with an official stamp.
I confirm that all the details given in this form are, to the best of my knowledge, true, accurate and complete.

Signature _____

Date DD / MM / YYYY

Official stamp of medical provider

Please submit your fully completed Pre-authorization Form, at least five working days before treatment to:

medicassist@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.*