

Group Claim Form

Please complete this form in **BLOCK CAPITALS.**

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Swift code of intermediary bank (where applicable)

^{***} Cheques payable to the policyholder will be sent to the correspondence address provided in section 1.





 ^{*} If you have not already paid the medical provider.
 ** For bank transfer, please provide bank details.

4 Claim details

Please complete all parts of the following table with the details of each invoice/receipt.

Please note that for costs incurred in China, you must submit a FaPiao invoice. If your invoice/receipt does not include the diagnosis/medical condition, you must give this information below. If there is insufficient space in the table below, please provide details on a separate page.

Date	Description of exp treatment	ense	e/		[Diag	nosis	s/m	edico	al c	ondi	tio	n		Pro	vide	r's r	nam	е				nou arg		Cı	urre	ency			ve y s bil		paid
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 $Please send \ us \ a \ copy \ of \ the \ police \ report \ if \ available \ to: claims.recoveries @allianzworldwidecare.com$

5	5 Medical provider's details	
	Name of doctor/specialist	
	Qualifications/credentials	
	Name of hospital/clinic	
	Address	
	Phone number COUNTRY CODE AREA CODE	
	Fax number COUNTRY CODE AREA CODE	
	Email	
	Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details:	
	Name of referring doctor	
	Phone number COUNTRY CODE AREA CODE	
	Date of referral DD / MM / YYYYY	
6	6 Medical details	
	Indicate type of condition: Acute ☐ Chronic ☐ Acute episode of chronic ☐	
	Please provide full details of the symptoms or medical condition requiring treatment:	
	ICD9/10 code/DSM-IV	
	Details of the symptoms/medical condition	
	On what date did the patient first present these symptoms to you ?	
	On what date would the first onset of symptoms have been apparent to the patient?	
	Please sign and authenticate with an official stamp.	
		cial stamp of medical provider
	_0	
	Doctor's signature	
	Date DD / MM M / YYYY	
7	7 Your personal data	
	Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process yo	ur personal data You should
	read it before submitting any personal data to us. To read our Data Protection Notice, visit: www.allianzcare.com/en/privacy.html	•
	Alternatively, you can contact us on + 353 1 630 1301 to request a paper copy of our full Data Protection Notice. If you have any qu	ueries about how we use your
	personal data, you can always contact us by email at: AP.EU1DataPrivacyOfficer@allianz.com	
8	3 Declaration	
	I certify that to the best of my knowledge, this Claim Form does not contain any false, misleading or incomplete information. I unde	
	to be fraudulent, in whole or in part, the contract will be cancelled from the date the fraud is discovered and I may be liable to pros	
	I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I authorise health professional or other relevant medical establishment to provide relevant medical information about me, if requested by Alli advisers or its appointed representatives, or to any third-party expert(s) in case of disputes, subject to any legal restrictions which medical secrecy confidentiality in respect of my medical information and I authorise health professional or other relevant medical establishment to provide relevant medical information about me, if requested by Alli	ianz Care, to its medical
	If a minor was treated a parent or guardian should sign and date this section	

Patient's signature

Date DD / MM / YYYY

9 We need your consent

In line with the General Data Protection Regulation (GDPR), we need your consent to process your medical information and pay your medical expenses. If you have not yet provided us with your consent, please access my.allianzcare.com/myhealth/login, login and tick the required fields. Alternatively, you can download the Consent Form from www.allianzcare.com/en/consent-form. A paper copy is available on request. Please note that every member on the policy over 18 must provide their own consent.

10 Third party authorisation

As the claimant, I hereby au	:horise							11	NSER	T NAN	1E OF	THIRE	PART	Υ							
to act on my behalf in relation	on to the adminis	tration of	this clo	ıim. Th	nis mo	ay inc	lude	the	discl	osur	e of s	ensit	ive m	edic	al in	orm	atior	٦.			
A																					
Claimant's signature																					
Claimant's signature Claimant's printed name									T								Т				

It is your responsibility to retain any original supporting documents (e.g. medical receipts) when you send us copies, as we reserve the right to request original supporting documents up to 12 months after each claim has been settled, for auditing purposes. We also reserve the right to request a proof of your payment (e.g. bank or credit card statement) in respect of your medical receipts. We advise you to keep copies of all correspondence with us as we cannot be held responsible for correspondence that does not reach us for any reason that is outside of our reasonable control.

Please send your fully completed Claim Form(s) with invoices/receipts by:

Email to: claims@talent-trust.com

Did you know...

...that most of our members find that their queries are handled quicker when they call us?

If you have any queries, please contact our Helpline on: + 353 1 9075903.

FRM-GCF-TT-EN-0524