Claim form

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

You can also use our MyHealth Digital Services to submit your claim online: **www.allianzcare.com/en/myhealth**

1 Policyholder's details

Allianz Care policy number

Date of birth D D / M M / Y Y Y Y

First name

Surname

Latest correspondence address

Telephone number COUNTRY CODE AREA CODE

Email

Do you have any national/public or state provided health insurance cover in your home country or country of residence e.g. National Health Insurance? Yes ☐ No ☐

If Yes, please name the cover provided. Please give your reference number/identifier with the state.

2 Patient details (Person taking treatment), (if different from policyholder)

First name

Surname

Date of birth D D / M M / Y Y Y Y Gender: Male ☐ Female ☐

3 Payment details

Please EITHER tick option 1 OR tick and complete option 2.

Option 1: Payment to medical provider* (e.g. hospital, specialist) ☐
The bank details requested below are not required for this option.

Option 2: Payment/ reimbursement to policyholder ☐

Please **specify the currency** you would like to be **reimbursed** in (and ensure that your bank account supports it)

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

ABA/ACH code (for US bank accounts only)

Account beneficiary's address in the USA

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)

* If you have not already paid the medical provider.

** 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.

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 Fa Piao 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.

Description of expense/ treatment	Diagnosis/medical condition	Provider's name	Amount charged	Currency	Have you paid this bill?
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
		Total Amount of Expenses (Please note that the total displayed here is only accurate when all invoices are issued in the same currency. If you are claiming costs in different currencies, please ignore the total amount displayed)	0.00		

In what country did the hospitalisation and treatment take place?

If the hospitalisation and treatment you received took place in India, please submit your claim to Bajaj Allianz at below address:

Bajaj Allianz General Insurance Company Ltd, 2nd Floor, Bajaj Finserv Building, Behind Weikfield IT park, Off Nagar Road, Viman Nagar, Pune 411014

Toll free phone: 1800-103-2529

1800-22-5858 (within India)

If the hospitalisation and treatment you received took place outside India, please submit your claim to Allianz Care to the address at the end of this form.

If this claim is resulting from an accident or work-related illness/injury and you hold any other insurance policy (e.g. car insurance, workmen compensation insurance policy), or if you are filing a claim or lawsuit against a third party to recover the costs incurred as a result of this accident/injury, please provide details in a separate document.

Sections 5 to 7 are to be completed by the treating doctor unless the information is detailed in the supporting documentation (e.g. receipts or invoices).

5 Medical provider's details

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Telephone 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

Telephone number COUNTRY CODE AREA CODE

Date of referral D D / M M / Y Y Y Y

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**? D D / M M / Y Y Y Y

On what date would the first onset of symptoms have been **apparent to the patient**? D D / M M / Y Y Y Y

Has the patient suffered from this condition previously? Yes ☐ No ☐

If Yes, when? D D / M M / Y Y Y Y

Are you aware of any treatment given for this or any related illness in the past? Yes ☐ No ☐

If Yes, please provide details

Is it likely to re-occur? Yes ☐ No ☐

Does it need rehabilitation? Yes ☐ No ☐

Is it permanent? Yes ☐ No ☐

Does it need long-term monitoring, consultations, check-ups, examinations or tests? Yes ☐ No ☐

Applicable to cases of pregnancy only:

Estimated date of delivery D D / M M / Y Y Y Y

Is birth of a single baby expected? Yes ☐ No ☐

If twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction? Yes ☐ No ☐

If Yes, please provide further details

Applicable to dental treatment claims only:

Was the patient suffering from dental pain at the time he/she visited you for treatment? Yes ☐ No ☐

7 Our Hospital/medical establishment/nursing home/doctor declare, agree, and undertake as under:

(a) We have no objection to any authorized official of the company/Allianz Care verifying documents pertaining to hospitalization and treatment of the above Patient and take copy of any required document/s.

(b) All valid original documents duty countersigned by the insured/Patient will be sent to the Company/Allianz Care within 7 days of the Patient's discharge.

(c) All non-medical expenses, OR expenses not relevant to hospitalization or illness of Patient, OR expenses disallowed in the Authorization Letter of the Company, OR arising out of incorrect information in the pre-authorisation form will be collected from the Patient/insured.

(d) We agree that the Company/Allianz Care will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.

(e) The patient declaration has been signed by the Patient or by his representative in our presence.

(f) We agree to provide clarifications for the queries raised regarding this hospitalization/treatment of the Patient and we take the sole responsibility for any delay in offering clarifications.

Please sign and authenticate with an official stamp.

Official stamp of medical provider

Doctor's signature

Date D D / M M / Y Y Y Y

8 We care about your personal data protection

Our Privacy Policy explains how Bajaj Allianz General Insurance Company Ltd ("Company", "We", "Us", "Our") use and or protect your privacy. This is an important notice which outlines how we our service providers will process your personal data and should be read by you before the submission of any personal data to us. To read our Privacy Policy visit: **https://www.bajajallianz.com/about-us/privacy-policy.html**.

If you have any queries about how we use your personal data, you can always contact us by e-mail at: **customercare@bajajallianz.co.in**

9 Declaration

a) I certify that to the best of my knowledge, this Claim Form does not contain any false, misleading or incomplete information nor the claim supporting documents submitted are in anyway forged/fabricated. I understand that in the event that this claim is found to be false, fraudulent, in whole or in part or forged and or fabricated claim supporting documents are submitted, your claim shall be repudiate and also the insurance contract will be cancelled from the date of discovery of the fraudulent event which is apart from forfeiting the premium and I may be liable to prosecution.

b) I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I authorise my medical practitioner, health professional or other relevant Hospital/medical establishment/Nursing Home to provide relevant medical information/original documents relating to me, if requested by the Company/Allianz Care, its medical advisers, its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply.

c) I agree to sign on the final bill and the discharge Summary, before my discharge.

d) Payment to Hospital/medical establishment/Nursing Home is governed by the Standard Terms and Conditions of the Policy.

e) In case the company is not liable to settle the hospital and treatment bill, I undertake to settle the bill as per the Standard Terms and Conditions of the Policy.

f) All non-medical expenses and expenses not relevant to current hospitalization and treatment and the amounts over & above the limit authorized by the company not governed by the Standard Terms and Conditions of the Policy will be paid by me.

g) I hereby declare to abide by the Standard Terms and Conditions of the Policy and if at any time the facts disclosed by me are found to be false or incorrect, I forfeit my claim, and the policy becomes void ab initio and also agree to indemnify the company.

h) I agree and understand that the Company is in no way warranting the service of the Hospital/medical establishment/Nursing Home and the Company/Allianz Care is in no way guaranteeing that the services provided by the Hospital/medical establishment/Nursing Home will be of a particular quality or standard and or deficiency of their services.

i) I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement suppression or concealment with respect to the claim and or if forged/fabricated claim supporting documents are submitted, then my right to claim reimbursement of the said expenses shall be absolutely forfeited.

j) I agree to indemnify the Hospital/medical establishment/Nursing Home against all expenses incurred on my behalf, which are not reimbursed by the Company.

If a minor was treated, a parent or guardian should sign and date this section.

Patient's signature _____

Date D D / M M / Y Y Y Y

10 We need your consent

In line with the applicable privacy laws in India for treatment and or claims outside India we need consent to process your medical information and pay your medical expenses. If you haven't provided us with your consent, please access **my.allianzworldwidecare.com**, login to Online Services and tick the required fields. Alternatively, you can download the Consent Form, available at www.allianzcare.com/en/consent-form/.

A copy is available on request. Please note that every member on the policy over 18 years of age needs to provide their own consent. Provided however, the policyholder (upon our issuing the policy) and the patient shall be deemed to have given express consent (as required hereinabove under Indian Laws) as per Privacy Policy at **https://www.bajajallianz.com/about-us/privacy-policy.html** and in this regard the policyholder and the patient undertake not to dispute or raise concerns as to his/her consent. You are deemed to have given express consent to us, upon your accessing/browsing to our website, upon continued customer relations with us. You are also deemed to have given express consent to us for our sharing to our group companies, our sharing to our service providers/ vendors (in India or outside India) who help BAGIC in Policy/claim servicing or for other services to be availed by us our for our processing for renewal/cross selling/upselling BAGIC products/services. I agree that my consent in this form is deemed as express consent to the company/Allianz Care for all purposes required under applicable Laws.

11 Third party authorisation

As the claimant/patient, I hereby authorise _____ INSERT NAME OF THIRD PARTY

to act on my behalf in relation to the administration of this claim. This may include the disclosure of sensitive medical information.

Claimant's signature _____

Claimant's printed name _____

Date D D / M M / Y Y Y Y

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 any supporting invoices/receipts/bills (credit card slips cannot be accepted) by:

Email to: claims@allianzworldwidecare.com

Fax to: + 353 1 645 4033

Post to: Claims Department, Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

Did you know...

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

Important – please check the following:

- ☐ All receipts, invoices and prescriptions are included.
- ☐ The Claim Form is completed in full.
- ☐ The declarations are signed and dated.
- ☐ The diagnosis has been confirmed and is stated either on the Claim Form or on the invoices.
- ☐ Your contact details are still correct (if they have changed, please let us know on the Claim Form).

If you have any queries, please contact our Helpline on: **+ 353 1 630 1301** or email: **client.services@allianzworldwidecare.com**
For our latest list of toll-free numbers, please visit: **www.allianzcare.com/toll-free-numbers**

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