

...peace of mind for whatever is beyond your horizon

Continuation of Claim Form

To be completed when submitting additional invoices in respect of an on-going medical or dental claim.

Please attach all original invoices. Photocopies, receipts and credit card slips cannot be accepted.

A separate Claim Form is required for each patient.

We recommend that you keep copies of all documents submitted, should you require them at a later date.

Are you covered? Where to send the claim form

It is important to check your policy to make sure that you are covered for the expenses for which you are claiming. If you are in any doubt as to what your policy covers, do not hesitate to contact our Helpline staff on:

T + 353 1 629 7140

Calls may be recorded or monitored for quality and training purposes.

F + 353 1 630 1306

E claims@alhealth.com

All claims correspondence should be sent to:

**à la carte healthcare claims
Allianz Worldwide Care Ltd
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland**

Policyholder & claimant details

Name of Policyholder (as shown on the Certificate of Insurance)	<input type="text"/>		
Policy Number	<input type="text"/>		
Name of Group (if applicable)	<input type="text"/>		
Name of claimant	<input type="text"/>		
Correspondence Address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>	Postcode	<input type="text"/>
Country	<input type="text"/>		
Date of birth (dd/mm/yyyy)	<input type="text"/>	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Telephone Number	<input type="text"/>	Fax Number	<input type="text"/>
Email Address	<input type="text"/>		

Claim details

Please note this section must be completed

Medical Condition or Dental Treatment	<input type="text"/>
Original Claim Settlement Number	<input type="text"/>
Date of Original Claim (dd/mm/yyyy)	<input type="text"/>
Date of Further Treatment (dd/mm/yyyy)	<input type="text"/>

Allianz Worldwide Care Limited underwrite the risk and administer claims on behalf of à la carte healthcare limited.

Amount claimed (continue on a separate sheet if necessary)

Description of expense: For example, Provider's name, prescription charges, X-ray etc	Amount charged (please specify the currency)	Date of Treatment (dd/mm/yyyy)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>
Total amount (please specify currency)	<input style="width: 95%;" type="text"/>	<input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>

Please attach all original invoices. Photocopies, receipts and credit card slips cannot be accepted.

Please note the following:

Where a currency conversion is required the rate will be that prevailing at the date of the invoice

Payment Details:

Payment to Policyholder Payment to Insured Payment to Provider

Payment to be made in: Invoice currency Other currency (Please specify)

Preferred payment method: Cheque Bank transfer (Please fill in bank details below)

Name of bank account

Account no./IBAN Sort/branch code

Swift code Bank name

Bank address

 Postcode

Declaration

I declare that to the best of my knowledge all particulars contained in this form are true. I hereby give my permission for any Doctor, Consultant or Dental Practitioner, or other authority mentioned herein to release further information regarding my medical records to à la carte healthcare limited and their appointed administrators. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Reports Act (AMRA) or other similar legislation. I understand that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for prosecution.

Data Protection Act

The Insurance Industry operates a number of anti fraud initiatives. The information on this form may be stored electronically and we may release certain information to other insurers or other interested parties. All data is maintained in accordance with the provisions of the Data Protection Act.

Signed (Policyholder/Claimant)

Date (dd/mm/yyyy) / /

(If patient is under 18 years, parent or guardian must sign)

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