

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

# Optical Claim Form

## 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, please feel free 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](mailto: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)

Policy Number

Name of Group (if applicable)

Name of claimant

Correspondence Address

Postcode

Country

Date of birth (dd/mm/yyyy)  Gender Male  Female

Telephone Number  Fax Number

Email Address

## Amount claimed (continue on a separate sheet if necessary)

Description of Expense	Amount charged (please specify the currency)
Eye examination carried out by an optometrist or ophthalmologist	<input type="text"/>
Prescribed glasses or contact lenses to correct vision	<input type="text"/>
Total amount (please specify currency)	<input type="text"/>

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

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 Medical Practitioner/General Practitioner/Nurse/Optomtrist or Ophthalmologist, 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)

### Medical Certificate

To be completed by the examining Medical Practitioner/General Practitioner/Nurse/Optomtrist or Ophthalmologist. Any fee for completion of this form is the responsibility of the Policyholder/Claimant.

**Optical**

Details of eye test/correction to vision

Date of Eye Test

Date of Last Test

Name and address of examining Optometrist/Ophthalmologist.

Postcode

Signature

Date (dd/mm/yyyy)

Official Stamp

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