

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

Routine Health Management 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

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"/>

Amount claimed (continue on a separate sheet if necessary)

Description of Expense	Amount charged (please specify the currency)
Hearing Test carried out by a medical practitioner	<input type="text"/>
Routine Health Check	<input type="text"/>
Well child test	<input type="text"/>
Vaccinations	<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, 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. Any fee for completion of this form is the responsibility of the Policyholder/Claimant.

Hearing Test

Details of Tests carried out

Routine Health Check

Details of Tests carried out

Well Child Test - details of tests carried out

Vaccinations

Details of immunisations or booster injections

Were they required under regulation of the country in which treatment is being given? Yes No

Details of travel vaccinations or malaria prophylaxis

Name and address of examining Medical Practitioner/General Practitioner/Nurse

Postcode

Signature

Official Stamp

Date (dd/mm/yyyy)

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