HEALTH
Insurance claim form

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NOTES
Claims for specialist consultations and any diagnostic procedures must be on the initial recommendation of your general practitioner, except for consultations/treatment given by gynaecologists, paediatricians or opthalmologists.

You must always contact Allcare Insurance Limited before receiving any in-patient treatment or C.T./M.R.I. scans, to enable us to confirm eligibility and extent of cover.

In an emergency situation you may contact us on 99 110 033.

Claim forms, together with original invoices and receipts, are to be submitted within 3 months of the intial date of treatment.

1A. POLICYHOLDER'S DETAILS

Title:	Name & Surname of policyholder:	I.D. card no.:	Date of birth of policyholder:
Address:			
Tel./Mob. no.:		E-mail address:	
Policy no.:		Group/Company name (if applicable):	

1B. PATIENT'S DETAILS

Title:	Name & Surname of patient:	I.D. card no.:	Date of birth of patient:
Address:			
Tel./Mob. no.:		E-mail address:	

2. TO BE COMPLETED BY THE PATIENT/LEGAL GUARDIAN

Reason for seeking medical advice:		
Date of patient's first visit to any medical practitioner for this condition:		
Did treatment require in-patient treatment?	☐ Yes	☐ No
If the answer is "YES", please advise	Admission date:	Discharge date:
Attach hospital certificate/s (if applicable):		
Are any of the costs recoverable from a third party?	☐ Yes	☐ No
If "YES", please give details:		

3. TO BE COMPLETED BY A REGISTERED MEDICAL OR DENTAL PRACTITIONER

Has the patient been treated for this condition before?	☐ Yes	☐ No
Details of the medical condition/symptoms:		
Diagnosis:	Date on which the symptoms were first noticed by the patient:	
Treatment given:	Treatment recommended:	
Does the patient require further treatment from a specialist?	☐ Yes	☐ No
Signature of General Practitioner:	Date:	

4. TO BE COMPLETED BY A MEDICAL SPECIALIST

Patient's name:	
Details of the medical condition/symptoms:	
Diagnosis:	
Treatment given:	Treatment recommended:
Specialist's Signature:	Date:

5. PAYMENT DETAILS

Payment will be made in the name of the policyholder. We reserve the right to send any payment to an appropriate person, for example, the executors of the will of someone who has died or the dependant on your policy who has paid the bill.

Payment may be made by electronic transfer when the bank account details are provided. This payment method and banking of cheques may result in charges by your bank, which are your responsibilty. Should you wish payment to be made by direct credit please provide us with complete bank details below:

Account holder's name:	
Bank name:	
Bank address:	
Account no.:	
Sort code:	

6. PAYMENT DETAILS

I authorise Allcare Insurance Limited to share information with others (including insurers and Insurance Associations) in order to prevent fraudulent claims. I declare that all the answers given and the statements made are true and correct. Furthermore I declare that I have not withheld any information relevant to the claim. I give explicit and unequivocal consent to Allcare Insurance Limited or its duly authorised agent acting on its behalf to seek any information from any doctor, surgeon, hospital, clinic, laboratory or persons that have records or knowledge of my health in order for the validity of the claims to be established.

I hereby authorise any doctor, surgeon, hospital, clinic, laboratory or person that have records to provide full medical information concerning myself and my dependants.

I give consent to Allcare Insurance Limited to process my personal data supplied by myself or any person, body or entity in order to process, handle and settle the claim.

Patient's signature: (If the patient is under 18 years of age, then legal guardian must sign)	Date:

7. DATA PROTECTION

In terms of the Data Protection Act, 2001, we (Allcare Insurance Limited) will process any personal and/or sensitive data supplied on/in this form for the processing and settling of claims; detecting, preventing and suppressing fraud; establishing, exercising or defending any legal action; and the keeping of statistics. We implement appropriate measures and safeguards for the purpose of protecting the confidentiality, integrity and availability of all data processed. You may also request access to and rectification of your personal data by writing to Allcare Insurance Limited. Kindly inform us by ticking the box below should you not want to receive any direct marketing. A copy of our Data Protection Policy is available on www.allcare.com.mt and from our offices.

8. DECLARATION

I/We authorise Allcare Insurance Limited to share information with others (including insurers and Insurance Associations) in order to prevent fraudulent claims. I/We give explicit and unequivocal consent to Allcare Insurance Limited or its duly authorised agent acting on its behalf to seek any pertinent information from any doctor, surgeon, hospital, clinic, laboratory or persons that have records or knowledge of my health to establish the validity of the claim. I/We hereby authorise any third party including, but not limited to, doctor, surgeon, hospital, clinic, laboratory or person that have records pertinent to the claim, to provide full information concerning myself and my dependants.

By signing this form, you confirm that you are giving your explicit consent, in terms of the Data Protection Act, on behalf of yourself and all the other persons specified in this form for the Company to process your respective personal information as outlined above and you confirm that you have brought this Data Protection Notice to the attention of these other persons and obtained their respective consents.

I/We declare that to the best of our knowledge and belief, these particulars are full and true and I/we have not withheld any information relevant to the claim. I/We agree to give any further information that may be required.

☐ **I do not consent to direct marketing**

I/We have read and agreed to the Data Protection Notice, the Declaration, and any other information relating to my/our rights.

Signature of Claimant:	Date: