Health Insurance Claim Form

Elmo INSURANCE

Notes:

- Please ensure that all sections of the claim form are fully completed to minimise any delays in handling your claim.
- If Section C and D are not completed in full we may require a separate medical report.
- Specialist treatment must be referred by the General Practitioner.
- Always enclose the original receipts and a copy of test results.
- Claims to be submitted within three (3) months of initial date of treatment.
- Clinic fees and waiting room fees are not refundable.
- Please contact us before receiving in-patient or day-patient treatment.

Section A: Policyholder's Details:

Policy Number | Passport No/ID Card Number

Title | First Name | Surname

Address

Tel Number | Mobile | E-mail

Section B: Patient's Details: (to be completed by the Patient. Parent or Guardian if patient is under 18)

Title | First Name | Surname | Date of Birth ____/____/____

1. Reason for seeking medical advice
2. Date patient first became aware of symptoms/condition ____/____/____
3. Is this the first claim for these symptoms/condition? Yes ☐ No ☐
4. Is this claim the result of any accident? Yes ☐ No ☐
5. Can you claim benefit for these symptoms/medical condition from any other source/s - such as another insurance policy?

Section C: General Practitioner: (to be completed by the GENERAL PRACTITIONER before you consult the specialist)

Name and Surname of Patient

Details of Condition, Symptoms & Diagnosis

Date patient first became aware of symptoms/condition ____/____/____

Date of first consultation for these symptoms/condition ____/____/____

Drugs/Treatment Prescribed

What other treatment/medication is the patient currently taking?

continued overleaf...

Details of specialist to whom patient has been referred

How long have you been the General Practitioner for this patient?

General Practitioner's signature [rubber stamp]

Telephone No.

Date: ____/____/____

Section D: Consultant Specialist: (to be completed by the SPECIALIST referred by General Practitioner above)

Name and Surname of Patient

Details of Condition, Symptoms and Diagnosis

Date Patient first became aware of symptoms/condition ____/____/____

Date of first consultation ____/____/____

Drugs/Treatment Prescribed

Name of hospital where the patient will be admitted

Procedure Code

Specialist's signature [rubber stamp]

Telephone No.

Date: ____/____/____

Data Protection Notice

I consent to the processing of my personal data by the Company or any other members of the Group supplied by myself as long as this processing relates to administering my health insurance policy, underwriting, handling and settling of claims, detecting, preventing and suppressing of fraud and the keeping of statistics. I authorise the Company to seek any medical information relating to myself or my dependants. I also authorise any doctor, hospital, laboratory or other health insurance provider to provide full medical information concerning myself or my dependants. I understand that the Company may, in addition, exchange information with others (including the Malta Insurance Association or other insurance companies) for the prevention of fraud. I authorise the Company to keep me informed of its products and services by mail, fax, e-mail or other electronic means. I understand that I may inform them in writing if I do not wish to receive this information.I also understand that I have the right to request access to my personal data by contacting Elmo Insurance in writing.

Declaration

I declare that to the best of my knowledge and belief, the statements and information given are true. If the information given on my behalf in Sections C and D of this claim form is insufficient for the Company's purposes, I consent to the Company obtaining a medical report from my Specialist or General Practitioner and contacting any person or organisation involved in my treatment. I understand that by consenting, I am permitting Elmo Insurance to use the information in the form and the medical report together with any extra information gathered during the claims process for the purposes of processing the claim or for other purposes permitted by law. I understand that without this consent Elmo Insurance may not be able to process this claim.

I also agree that a copy of this consent shall have the validity of the original claim form.

Patient's signature. Parent or guardian if patient is under 18 years.

Signature: _____ Date: ____/____/____

EIL.HTCF002/11/09

SEND YOUR COMPLETED FORM TO
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