

CLAIM FORM

Sana private medical insurance, Msida Road, Gzira, GZR 1405, Malta.



Please read carefully

- Please ensure that all sections of the claim form are completed in BLOCK CAPITALS and that you sign and date the back of the form.
- Treatment must be on initial referral of your General Practitioner.
- Eligible fees will be paid up to the limits of your policy and up to the maximum amounts we consider to be fair and reasonable.
- Claim forms must be submitted together with original receipts and an itemised list of all tests being carried out within 3 months from the date of treatment.
- Always contact us before receiving any treatment.
- If you have any queries, please call GasanMamo on (+356) 21 345123 or email sana@gasanmamo.com

Please complete a new/separate claim form:

- For each patient
- For each out/in/day-patient treatment
- For each medical condition

1 Policyholder/Patient details

Policyholder's Name & Surname		Passport/I.D. No.	
Patient's Name & Surname		Passport/I.D. No.	
Policy number		Group / Company name (if applicable)	
House name/ no.		Street	
Town		Postcode	Tel. No.
Mobile No.	Email		
Reason for seeking medical advice			
Have you previously claimed for this medical condition?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Date when symptoms started	
Are you covered for medical expenses under any other insurance policy?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		If yes, give details below	

2 Medical examination

General Practitioner's details			
Name of patient	Date of consultation		General Practitioner's signature & stamp
Name of GP			
Date symptoms first noticed by patient		Reg. No.	
Has the patient been treated for this condition before?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		GP Tel. No.	
Diagnosis / Symptoms / Treatment			
		Referred to	
Specialist's/Therapist's details (patient has to be referred by the GP above)			
Name of patient	Date of consultation		Specialist's / Therapist's signature & stamp
Name of Consultant			
Date symptoms first noticed by patient		Reg. No.	
Has the patient been treated for this condition before?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Consultant Tel. No.	
Diagnosis / Symptoms / Treatment			
		Referred to	
Date of operation		Procedure code/s	
Hospital/Clinic details			
Name		Signature of Hospital Official	
Admission date	Discharge date		

3 Declaration (To be signed by the patient)

In view of the declaration below it is essential that complete information is supplied.

It is GasanMamo's intention to provide a good service to our policyholder at all times. However, if you have any cause for dissatisfaction please write to the Managing Director, GasanMamo Insurance Ltd., Msida Road, Gzira GZR 1405. The law of Malta will apply to this contract unless you and us agree otherwise.

I understand that benefits may not be payable if I do not fully disclose any material facts which could influence GasanMamo's assessment and acceptance of my application. I agree to disclose facts even when I am in doubt as to whether they are material or relevant.

I agree to inform GasanMamo of any changes which may alter my policy and which have occurred since the policy started or since the last renewal date. Failure to do so may invalidate the policy or reduce cover.

Processing your data

I give explicit and unqualified consent to GasanMamo Insurance Ltd. within the provisions of the Professional Secrecy Act 1994 and the Data Protection Act 2001 to obtain and make use of personal information relating to myself and my dependants in order to allow GasanMamo to process this claim.

To the extent that the information supplied, whether orally or in writing, constitutes personal data, including sensitive data within the provisions of the Data Protection Act, I consent to the processing of such data for purposes of administering my proposal for insurance, my policy, underwriting, handling of claims and also for the purposes of detecting, preventing and suppressing fraud and of keeping statistics.

We may be required to collect further information from our Tied Insurance Intermediary, other insurance companies, insurance intermediaries or insurance associations. In addition, we may seek further information from any doctor, hospital, clinic, laboratory or any related practitioner to provide us with further medical information. This helps us to check the information provided. When you tell us about an incident which may or may not give rise to a claim, we may pass information relating to it to the Malta Insurance Association, other insurance companies, Tied Insurance Intermediary, brokers, or medical advisers for the purpose shown in the declaration.

We and other companies within our group would like, on occasion, to keep you informed of our products and services, by mail, fax, email or other electronic means. Please inform us in writing if you do not wish to receive this information or if you wish to receive such information solely from GasanMamo Insurance Ltd.

You have the right to request access to, and rectification of, your personal data held by us by directing your request in writing signed by yourself to the Data Protection Officer, GasanMamo Insurance Ltd., Msida Road, Gzira GZR 1405.

Important - Please read

- Claims payment may be delayed if all the sections of the form are not completed in full.
- This form **MUST** be returned to us completed immediately following treatment or within three months of the treatment date. Always enclose original invoices and receipts – photocopies and credit vouchers are not acceptable.

I declare that to the best of my knowledge and belief, the information given on this form is true and complete. I understand and accept that in the event of this claim form being fraudulent in whole or in part, the policy may be invalidated.

Patient's signature/Parent or guardian's signature if the patient is under 16.

Date