



## 5 Medical provider's details

Name of doctor/specialist																														
Qualifications/credentials																														
Name of hospital/clinic																														
Address																														
Telephone number	COUNTRY CODE			AREA CODE																										
Fax number	COUNTRY CODE			AREA CODE																										
Email																														

Applicable to **physiotherapy/psychotherapy** claims only. Please provide full referral details:

Name of referring physician																																							
Telephone number	COUNTRY CODE			AREA CODE																											Date of referral	D	D	/	M	M	/	Y	Y

## 6 Medical details

Indicate type of condition: Acute  Chronic  Acute episode of chronic

Please provide full details of the symptoms/medical condition requiring treatment, including ICD9/10 code/DSM-IV

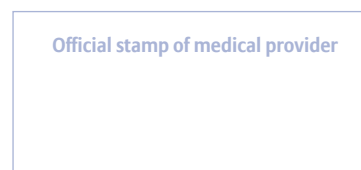

On what date did the patient first present these symptoms to you?   /   /

On what date would the first onset of symptoms have been apparent to the patient?   /   /

Please sign and authenticate with an official stamp.

Doctor's signature \_\_\_\_\_

Date   /   /



## 7 Data Protection and release of medical records

The processing of personal data is essential to the transaction of insurance business. In the processing of personal data, we comply with the Swiss Data Protection Act (DPA). We store data electronically or physically in compliance with the applicable and relevant legal provisions.

References to information include personal information given by you to us, in your Application, Claim or Treatment Guarantee Form and/or supporting documents/information we collect in connection with products or services we provide.

**Uses:** The personal data processed by us include data relating to and for the purposes of preparing quotations, underwriting policies, collecting premium, paying claims and for any other purpose which is directly related to administering policies in accordance with the insurance. We may use third parties to process data on our behalf. Such processing, which may take place outside the European Economic Area (EEA), is subject to contractual restrictions regarding confidentiality and security in line with Data Protection obligations. We also process personal data in connection with product enhancements, as well as for our own marketing purposes. In order to offer affordable comprehensive insurance cover, our services may partly be provided by legally independent firms both domestically and abroad.

**Sensitive data:** We need to collect sensitive data relating to you (e.g. health details), to assess insurance terms and/or administer claims.

**Disclosure:** We may share your information with our agents, members of the Allianz Group, reinsurers, other insurers and their agents, previous domestic and foreign insurers, service providers, any intermediary acting on your behalf or governing/regulatory bodies (of which we are a member or by which we are governed). In certain circumstances, we may use private investigators to investigate a claim you have submitted.

**Retention:** We are obliged to retain your records for six years from the date the insurance relationship ends. We will not retain your data for longer than necessary and will hold it only for the purposes for which it was obtained.

**Representation and Consent:** By signing this form you confirm that you have the authority to act on behalf of your dependants in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependants.

**Access:** You have the right in accordance with the DPA to request and receive a copy of your personal data held by us and may also request rectification of incorrect data. If you wish to do this, please write to the Data Protection Officer at the address provided on this form or via [client.services@allianzworldwidecare.com](mailto:client.services@allianzworldwidecare.com).

**Call recording:** Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes.

I certify that to the best of my knowledge, this Claim Form does not contain any false, misleading or incomplete information. I understand that in the event that this claim is found to be fraudulent, in whole or in part, the contract will be cancelled from the date of discovery of the fraudulent event and I may be liable to prosecution.

I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I authorise my medical practitioner, health professional or other relevant medical establishment to provide relevant medical information relating to me, if requested by my Insurer, its medical advisers, its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply.

If a minor was treated, a parent or guardian should sign and date this section.

Patient's signature \_\_\_\_\_ Date   /   /

## 8 Third party authorisation

As the claimant, I hereby authorise \_\_\_\_\_ (INSERT NAME OF THIRD PARTY)

to act on my behalf and on behalf of any dependants named on this form (where applicable), in relation to the administration of this claim which may include the disclosure of sensitive medical information.

Claimant's signature \_\_\_\_\_ Date   /   /

Claimant's printed name

*It is your responsibility to retain any original supporting documentation (e.g. medical receipts) where copies are submitted to us, as we reserve the right to request original supporting documentation/receipts up to 12 months after claims settlement for auditing purposes. We also reserve the right to request a proof of payment by you (e.g. bank or credit card statement) in respect of your medical receipts. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that does not reach us for any reason that is outside of our reasonable control.*

**Please send your fully completed Claim Form(s) with invoices/receipts as follows:**  
 By email to: [claims@allianzworldwidecare.com](mailto:claims@allianzworldwidecare.com), by fax to: + 353 1 645 4033, or by post to: Claims Department, Allianz Worldwide Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.