CLAIM FORM
2017 – 2018

MEDICARE LONG-TERM INTERNATIONAL HEALTH PLAN

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Insurance made easy.

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Insurance made easy.

Please write in **CAPITAL LETTERS** and tick relevant boxes. Failure to complete the form fully will delay settlement of your claim. Please ensure you have read the 'how to make a claim' section of the Policy Guide prior to making a claim.

Written notification of claims must be provided to us within 90 days of the initial consultation, even where original invoices are not yet available.

To help us deal with your claim promptly, please:

1. Complete a separate claim form for each person and each illness/accident/dental/pregnancy and childbirth/well being benefit claim.
2. Ensure that the doctor or dentist who treats you fully completes the sections overleaf.
3. ALL questions must be answered in full (ticks or dashes will not be acceptable).
4. ALL routine dental treatment must be supported with confirmation of an annual check up.
5. Original accounts for treatment received must be submitted.

The Assistance Company must be contacted for all claims under benefits requiring pre-authorisation and any claims likely to exceed £2,500/$4,250/€3,500. You will be responsible for the first £1,000/$1,700/€1,400 of treatment costs if you fail to obtain pre-authorisation before receiving treatment.

PATIENT INFORMATION (TO BE COMPLETED BY YOU/YOUR LEGAL REPRESENTATIVE)

A

1. Title: ○ Mr ○ Mrs ○ Ms ○ Miss ○ Other: .....
   Surname: .....
   First Name(s): .....
2. Date of Birth: d d / m m / y y y y
3. Certificate Number: .....
4. Gender: ○ Male ○ Female
5. Telephone:

6. Full Mailing Address: .....
   .....
   City: .....
   State/Region/County: .....
   Postcode:
   Country: .....
7. Email: .....

CLAIM INFORMATION (TO BE COMPLETED BY YOU OR YOUR LEGAL REPRESENTATIVE)

B

8. State the nature of the illness/symptoms:
   .....
   .....
9. Have you ever received treatment (including over the counter medication) for this condition or any related condition before this episode? ○ Yes ○ No
   If yes, please provide dates and details of previous treatment:
   .....
   .....
   .....
   .....
10. When did symptoms first occur?
    .....
11. If the cause of the illness relates to an accident, please state the date of the accident and give brief details of the circumstances and injuries received:
    Date: d d / m m / y y y y
    .....
    .....
    .....
12. Do you have any other insurance that provides cover for healthcare benefits? ○ Yes ○ No
    If yes, please provide details of the insurance policy:
    .....
    .....
    .....
13. Please complete the following table

Date of treatment	List expenses for which reimbursement claimed (Original accounts will be required)	State currency and amount paid	State in full, to whom you wish settlement paid*	Currency of settlement*

* Please complete section E, bank details, if applicable or not already supplied

14. Are further accounts to be submitted? ○ Yes ○ No
If so, please provide details:

.....

.....

.....

15. Is this a continuation of previous or current treatment for which you have already claimed under this plan?
○ Yes ○ No
If so, please provide details, including a claim reference number:

.....

.....

Ref: .....

16. Please provide the name and address of your usual General Physician:

Name: .....

Address: .....

City: .....

State/Region/County: .....

Postcode:

Telephone:

Email:.....

17. Please provide details of other doctors and/or surgeons who have treated you for this or related conditions:

.....

.....

.....

18. I authorise (1) the release of any medical information necessary to process this claim and (2) the processing of any medical information or other personal data provided by me or by my physician/dentist and the disclosure of such information to underwriters via claims handling agents and, where relevant to loss adjusters for the purpose of this claim. I declare that I have not received medical advice or treatment or experienced symptoms for the illness/injury for which I am now claiming within two years prior to the first date of my insurance cover under this policy. To the best of my knowledge all the details provided are true.

Signature:

Date: d d / m m / y y y y

THE SECTION(S) BELOW MUST BE COMPLETED BY THE TREATING PHYSICIAN/DENTIST

MEDICAL INFORMATION (TO BE COMPLETED BY TREATING PHYSICIAN)

19. Please state the date on which the patient first consulted you for this or any similar or related condition:
Date: d d / m m / y y y y

20. Please describe the symptoms presented:

.....

.....

.....

.....

21. Please advise when these symptoms first occurred:

.....

22. Please detail your diagnosis of the illness/injury:

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23. Please provide a detailed history including dates of this or any related medical conditions for which previous treatment and/or investigation took place:

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.....

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24. Is the condition likely to be considered congenital or a birth defect?
○ Yes ○ No

If yes, please provide details:

.....

.....

25. If all or part of the treatment was in respect of elective cosmetic surgery, please indicate the amount or the proportion of the costs involved:

.....

26. In respect of claims for pregnancy and childbirth, please state the expected delivery date and the date on which the patient first consulted you for this pregnancy:
First consultation date: d d / m m / y y y y
Expected delivery date: d d / m m / y y y y

27. Please provide your name and address:

Name: .....

Address: .....

City: .....

State/Region/County: .....

Postcode:

Telephone:

Email:.....

Signature of treating physician:

Date: d d / m m / y y y y

Qualifications: .....

ROUTINE DENTAL TREATMENT INFORMATION (TO BE COMPLETED BY TREATING DENTIST)

28. Has the patient attended for a routine check-up in the past 12 months and was all necessary treatment concluded?
○ Yes ○ No

29. In your opinion has the patient maintained good dental hygiene? ○ Yes ○ No
If not, please provide details:

.....

.....

.....

30. Please describe the dental necessity for this claim:

.....

.....

.....

31. Please provide your name and address:

Name: .....

Address: .....

City: .....

State/Region/County: .....

Postcode:

Telephone:

Email: .....

Signature of treating dentist:

Date: d d / m m / y y y y

Qualifications: .....

D

BANK DETAILS

Please note that our bank requires the BANK SWIFT/BIC number AND the BANK IBAN number for ALL International Transfers of Funds.

Name of bank: .....

Bank address: .....

.....

City: ..... State/Region/County: .....

Postcode: Country: .....

Account holder: .....

Account number:

Sort Code (UK only):

BIC/Swift Code:

IBAN No:

E

SUBMITTING THE FORM

Please submit the completed claim form along with the supporting invoices and/or receipts by post to:
April International UK, Minster House, 42 Mincing Lane, London, EC3R 7AE United Kingdom

If the claim is less than £1,000/$1,700/€1,400 you can submit the claim form and copies of the invoices and/or receipts by email to:
claims@april-international.co.uk

You must retain the original documents as we have the right to request them.

F

Please note that APRIL International UK has authority from the insurers to handle claims on their behalf subject to certain limitations. If you do not wish us to act on this claim as an agent of both yourself and insurers, you should advise us by return and we will arrange for handling of your claim to be managed by insurers themselves.

DATA PROTECTION ACT Any information you have provided will be dealt with by APRIL International UK and the Insurer of the plan in compliance with the provisions of the Data Protection Act 1998. For the purpose of providing this insurance and handling or any claims or complaints which may arise under it, APRIL International UK and the Insurer of the plan may need to transfer certain information which you have provided to other parties. By signing this proposal you agree that such transfer(s) may be made.

april international | UK

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Insurance made easy.