CARE
Your Health Is Our Priority

Medical Expenses Claim Form

Please complete in BLOCK capitals ensuring ALL relevant fields are completed.

Sections 1, 2 and 3 to be completed by the Policyholder. Sections 4 and 5 to be completed by the Provider of Treatment

1. Policyholder Details | As shown on your membership card

Member Number:

Member Number Policy Number:

2. Patient Details

Date of Birth:

Title: Mr ☐ Mrs ☐ Miss ☐ Dr ☐

First Name(s):

Surname:

1. Are you claiming cash benefit for in-patient treatment received without charge? If "Yes", please state the admission and discharge dates and enclose a certificate from the hospital confirming the dates of stay: **Yes** ☐ **No** ☐

Admission Date (DD/MM/YY):

Discharge Date (DD/MM/YY):

2. If the claim is related to pregnancy what was the date of your last monthly period: (DD/MM/YY)

   The date on which the pregnancy was confirmed:

   Estimated Delivery Date:

3. Is this claim the result of an accident for which a claim may/is to be made against a third party? If "Yes" please provide details: **Yes** ☐ **No** ☐

4. Are there either completely or in part any expenses that are recoverable from any other source or insurance policy? If "Yes" please provide details: **Yes** ☐ **No** ☐

5. Has the Policy Excess been Paid? If "Yes" to whom? **Yes** ☐ **No** ☐

6. Has the European Health Card been used? **Yes** ☐ **No** ☐

3. Payment Details | Our usual practice is to settle eligible bills directly with the physician or hospital concerned. If you have already paid the invoices yourself please send us the receipts and we will reimburse you if, and to the extent that, there is cover, by cheque or wire transfer direct to your bank account. For reimbursements, please complete this section with your bank account details. We cannot reimburse to credit or debit cards, so please do not list any card numbers on this form.

Full name of the payee:

Name and address of the bank:

Account Holder's Name:

Account Number:

Bank Sort Code:

IBAN Number:

Swift/BIC Number:

4. Medical Practitioner Information: To be completed by the Provider of Treatment

Name of Doctor/Specialist:

Name and address of Hospital/Clinic:

Telephone:

Email address:

5. Medical Treatment Details: To be completed by the Provider of Treatment

1. Please provide full details of the medical condition requiring treatment along with full details of any investigations, treatment or surgical procedures including the results if already carried out.

ICD CODE or relevant diagnostic code:

OPCS CODE or relevant surgery code:

2. On what date did the patient first present to you or any other doctor for this condition? (DD/MM/YY)

3. Prior to consulting you, when did the patient first notice any signs or symptoms of this condition? (DD/MM/YY)

4. Are you aware of any treatment, investigations, advice, medication, or has the patient followed any special diet for this or any related illness in the past? If "Yes" please give details and dates: **Yes** ☐ **No** ☐

5. Please give any other medical history relevant to the illness or injury being claim for:

6. Future treatment plan, including proposed frequency and overall length of treatment and expected dates of treatment sessions:

7. Circumstances of injury or illness:

Doctor's Signature:

Doctor's stamp:

Date (DD/MM/YY):

PLEASE READ THE STATEMENTS MADE ON THE REVERSE OF THIS FORM AND ANSWER THE QUESTIONS, SIGN AND DATE THE FORM.

FAILURE TO DO SO MAY AFFECT THE INSURER'S ABILITY TO PROVIDE THE INSURANCE COVER FROM WHICH YOU BENEFIT AND MAY PREVENT THE INSURER FROM PROVIDING COVER FOR YOU AND HANDLING YOUR CLAIMS.

Your personal information notice

Who we are: The insurer identified in the Certificate of Insurance and the Policy Wording – namely, HDI Global Specialty SE
The basics: The insurer collects and uses relevant information about you to provide you with your insurance cover or the insurance cover that benefits you and to meet its legal obligations. This information includes details such as your name, address, contact details, and any other information that the insurer collects about you in connection with the insurance cover from which you benefit. The information includes details that are more sensitive information about your health.
In certain circumstances, the insurer may need your consent to process information about your health. Where it needs your consent, you will be asked for this separately. You do not have to give your consent and you may withdraw your consent at any time. However, if you do not give your consent, or you with draw your consent, this may affect the insurer's ability to provide the insurance cover from which you benefit and may prevent the insurer from providing cover for you or handling your claims.
The way insurance works means that your information may be shared with, and used by, a number of third parties in the insurance sector for example, insurers, agents or brokers, reinsurers, loss adjusters, sub- contractors, regulators, law enforcement agencies, fraud and crime prevention and detection agencies and compulsory insurance databases. The insurer will only disclose your personal information in connection with the insurance cover that it provides and to the extent required or permitted by law.
Other people's details you provide to the insurer: Where you provide the insurer or your agent or broker with details about other people, you must provide this notice to them.
Want more details: For more information about how the insurer uses your personal information please see its full privacy notice which is available online on its website https://www.hdi.global/legal/privacy/. or in other formats on request.
Contacting us and your rights: You have rights in relation to the information the insurer holds about you, including the right to access your information. If you wish to exercise your rights, discuss how the insurer uses your information or request a copy of its full privacy notice, please write to: The Data Protection Officer: HDI Global Specialty SE, Podbielskistraße 396, 30659 Hannover, Germany, Tel. +49 511 5604-2909
E-mail: contact@hdi-specialty.com

HDI Global Specialty SE is a Data Controller as defined under the EU General Data Protection Regulation ('GDPR'). You can reach our Data Protection Officer by post at the aforementioned address (please include the additional address line "Data Protection Officer") or by e-mail via our data privacy group mailbox:
E-mail: privacy-hgs@hdi-specialty.com
Please provide your broker's company name when writing to the insurer.

Personal Information and Access to Medical Information Consent Wordings

a) Your personal information and access to your medical information:
This section applies if you are the patient i.e. the person to whom this claim relates and are aged 14 or over at the time of completion of this Claim Form.
The insurer - namely, HDI Global Specialty SE need your consent to use the sensitive details about you included in this Claim Form and to request medical information, ifneeded, from your physician in connection with your claim.
"Other insurance market participants" include the insurer's third party agent named HealthWatch SA (for the purposes of claims assessment, decision making and administration).
You do not have to give your consent and you may withdraw your consent at any time. However, if you do not give your consent, or you withdraw your consent, this may prevent the insurer from handling or otherwise affect its ability to handle your claim.
If the insurer needs medical information from your physician in connection with your claim, you have a right to see this information before it is provided to the insurer. If the insurer needs the medical information – and you have given your consent to it being requested – you will be advised in writing of the date it was requested.
If you exercise your right to see the medical information, the insurer will request that your physician keep it for 21 days from the date it is requested so that you can arrange to see it. If you have not arranged to see the medical information within this time, your physician will be entitled to send it to the insurer.
If you choose not to see the medical information from your physician at this stage, you may ask them for a copy or the insurer for a copy (which the insurer will send to your physician).
If, having chosen to see the medical information, you think that any of it is not correct or is misleading; you may ask your physician to amend it. If your physician refuses to do this, you may ask them to attach a statement outlining your views, which will then accompany the medical information.
Your physician may charge you for their provision of your medical information. Please note that, if they do, the cost is not recoverable under your DCare International Medical Insurance policy.
Your physician can withhold access to your medical information if, and to the extent that, they are of the opinion that it would cause physical or mental harm to you or others.

In connection with your claim do you consent to:

The use of data and information about your health;	YES ☐	NO ☐
The insurer requesting your medical information, if needed from your physician;	YES ☐	NO ☐
Your physician providing your medical information if needed to the insurer;	YES ☐	NO ☐
If the insurer needs to request your medical information from your physician in connection with your claim, do you want to see this before it is sent to the insurer?	YES ☐	NO ☐

b) Another person's personal information and access to his or her medical information.
This section applies if you are not the patient i.e. you are not the person to whom this claim relates but the patient is below the age of 14 years at the time of completion of this Claim Form and you are a holder of parental responsibility over them.
Where you provide the insurer with details about another person, it and other insurance market participants need their consent to use the sensitive details about them included in this Claim Form and to request medical information if needed, from their physician in connection with their claim.
"Other insurance market participants" include the insurer's third party agent HealthWatch SA (for the purposes of claims assessment, decision making and administration).
However, where the other person is a child below the age of 14 years at the time of completion of this Claim Form, the consent must be given by a holder of parental responsibility over the child.
Consent does not have to be given and may be withdrawn at any time. However, if consent is not given, or if it is withdrawn, this may prevent the insurer from handling or otherwise affect its ability to handle the other person's claim.
If the insurer needs medical information from the other person's physician in connection with their claim, they have a right to see this information before it is provided to the insurer.
If the insurer needs the medical information - and consent has been given to it being requested – the other person will be advised in writing of the date it was requested. However, if the other person is a child below the age of 14 years at the time of completion of this Claim Form, this advice will instead be provided to the relevant holder of parental responsibility over the child.
If the right to see the other person's medical information is exercised, the insurer will request that their physician keep it for 21 days from the date it is requested so this can be arranged. If arrangements have not been made to see the medical information within this time, the physician will be entitled to send it to the insurer.
If the right to see the other person's medical information from their physician is not exercised at this stage, a copy may be requested from the physician or from the insurer. If a copy is requested from the insurer, they will send this to the physician.
If, having exercised the right to see the other person's medical information, any of it is thought to be not correct or misleading; their physician may be asked to amend it. If the physician refuses to do this, they may be asked to attach a statement outlining the (contrary) views, which will then accompany the medical information.
The other person's physician may charge for their provision of the medical information. Please note that, if they do, the cost is not recoverable under the DCare International Medical Insurance policy. The other person's physician can withhold access to the medical information if, and to the extent that, they are of the opinion that it would cause physical or mental harm to that person or to others.

For each person (who is a child below the age of 14 years at the time of completion of this Claim Form) are you a holder of parental responsibility over them?	YES ☐	NO ☐
For each such person in connection with their claim, do you give consent in the capacity of being a holder of parental responsibility over them to;	YES ☐	NO ☐
The use of data and information about their health;	YES ☐	NO ☐
The insurer requesting their medical information if needed from their physician;	YES ☐	NO ☐
Their physician providing their medical information if needed to the insurer;	YES ☐	NO ☐
If the insurer needs to request medical information from other person's or persons' physician in connection with their claim, do you want to see this before it is sent to the insurer?	YES ☐	NO ☐

Declaration

I declare that I am the patient, meaning a) or the person to whom this claim relates).	YES ☐	NO ☐
I declare I am not the patient but the patient is a child below the age of 14 years at the time of completion of this Claim Form and I am a holder of parental responsibility over them.	YES ☐	NO ☐
I declare that the information I have supplied in this Claim Form is true and fully accurate to the best of my knowledge.	YES ☐	NO ☐
I understand that, if I do not take reasonable care to answer all questions in this Claim Form accurately, or if the policy terms and conditions are not complied with, this may result in a claim being delayed, only partially paid or not paid at all.	YES ☐	NO ☐

Signed:

Full Name (Please Print):

Date (DD/MM/YY):