Allianz AYUDHYA

Compassionate emergency visit Claim form

Please complete clearly in BLOCK CAPITALS.

One form must be completed for each claimant.
Further information about how to complete this form can be found on the reverse.

Failure to complete all sections marked 'must be completed' on this form may result in delays.

Section A: Patient details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ Male ☐ Female
Member number:	Plan number:
Correspondence address:	
Town:	Postcode: / Country:
Email:	
Daytime phone:	Evening phone:

Section B: Main member details (if different from section A)

Family name (surname):	First name(s):
Member number:	Plan number:

Section C: Compassionate emergency visit expenses – must be completed

Details of the close family member you are visiting.

Family name (surname):	First name(s):
Relationship to the claimant:	

Attach a copy of the birth certificate/a copy of the marriage certificate or other official documents for proof of relationship.

Is/was the close family member critically ill? ☐ Yes ☐ No
If 'Yes', please provide original medical report.
If the family member is deceased please provide a copy of the death certificate and/or a copy of the funeral notice.

Date(s) of travel (dd/mm/yyyy):

Please attach the original booking invoice and boarding pass.

Did you request pre-authorisation? ☐ Yes ☐ No

Provide the breakdown of the r eceipts being submitted:

Type of expenses claimed	Receipt date (dd/mm/yyyy)	Receipt reference	Amount (including currency)

Use a separate sheet if you need more space.

Section D: Data Protection and Declaration

Data Protection Notice

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confi dential and will be processed in accordance with relevant legislation and our own strict internal policy.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

Any medical information we hold will only be disclosed to those involved with a patient's treatment or care, including the general practitioner/primary health physician, or to their agents.

We will communicate directly with you about your claim. Claims information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information, or to another person that you have authorised us to provide such information.

Claimant's/main member's signature:	Relationship:

Declaration – must be signed by the claimant or the main member or guardian if the claimant is a dependant under the age of 20

I declare that all the details given on this Claim form ar e true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I may be committing a criminal of fence and that this may invalidate the plan.

I confirm that I give explicit consent (on behalf of myself and any family members speci fied in this form) for the insur er or their duly appointed administrators or authorised agents to process our personal information with respect to our membership and I confi rm that I have brought this Data Protection Notice to the attention of these family members.

I authorise and request any hospital, specialist, physician or other health provider to furnish the insurer or their duly appointed administrators or authorised agents with such information as they may seek from them in connection with any treatment or other services provided to me or my dependant/s for the purpose of the consideration of this claim.

Claimant's/main member's signature:	Date (dd/mm/yyyy):

Section E: Payment details

We will only issue payment to:

- the claimant if they are 20 or over;
- the planholder if the claimant is under 20 and is a dependant under the plan; or
- the parent or legal guardian named as the planholder, if the claimant is the main member and is under 20.

If another person or entity has paid on your behalf please give their name:

Failure to complete all information for the chosen reimbursement method may result in you, the named person or entity:

- experiencing delays in receiving the claim settlement; and
- incurring additional bank charges.

Name of account holder:

If the claimant's name (as given in section A) is different to the account holder name, please provide the following details:

Address of account holder:

Email address of account holder:

Telephone number of account holder:

Bank account details:

Bank name:

Bank address (including town and city):

BIC/SWIFT code:

Currency of bank account:

Account number:

To help us direct your payments efficiently, supply the following as relevant:

IBAN number (mandatory for all payments to bank accounts in countries that have adopted IBAN):

Sort code (mandatory for UK located banks):

Routing code/Branch code (as available):

ABA number (mandatory for transfers to US located banks) :

Important information

Please remember these important points when completing your Claim form:

- Assessment of your claim may be delayed if you do not complete all the necessary sections of this form.
- Send your claim to us as soon as possible. We recommend that you do so within a maximum period of six (6) months from the first date of travel.
- Receipts and credit card statements are not acceptable.

Section A – Claimant details

- If the claimant is a dependant under the age of 20, the main member must complete the form and sign the declaration for them. If the claimant is the main member and is under the age of 20, the parent or legal guardian named as the planholder must complete the form and sign the declaration for them.

Section D

If the declaration has not been read and signed, we will not be able to process your claim.

Section E – Payment details

i. Ensure that you are able to receive payment in the method and currency you have requested.

ii. We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.

iii. We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details .

iv. If you do not give us the sort code/routing code, BIC/SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.

v. We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the currency of your plan. For the current list of applicable currencies and countries please refer to our website.

vi. Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of the payment and is outside our control.

The no-claims discount applies to individual and family plans only. Claims made under the compassionate emergency visit benefit will affect your no-claims discount.

The no-claims discount does not apply to groups.

Checklist

Please send your claim to us by post. Please check you have included:

- a fully completed Claim form with signed and dated declarations ☐
- the original booking invoices ☐
- the original travel tickets or boarding passes ☐
- a copy of the birth/marriage certificate or a combination of documents proving relationship ☐
- the original medical report/a copy of the death certificate/a copy of the funeral notice ☐
- other relevant documentation ☐

If we have requested originals, photocopies will not be accepted.
We will be unable to return them but we are happy to provide certified copies on request.

Please call us on +66 (2) 662 8280 press 4 or email th-claims@aetna.co.th if you require any further assistance.

Send your claim to: IPMI Claims Team, Allianz Ayudhya General Insurance Public Company Limited.

898 Ploenchit Tower, Ploenchit Road, Khwang Lumpini, Khet Pathumwan, Bangkok 10330
T +66 (2) 662 8280 press 4 Office hours: 08.30-17.30