expacare

# CLAIM FORM

You can submit your claim form:

Email: claims@expacare.com
Online: www.expacare.com
Post: Expacare Claims Department,
Expacare Limited
Bracknell Enterprise Centre
Easthampstead Road
Bracknell, RG12 1NF
United Kingdom

If you have any questions, please call us:
+44 (0) 1344 233900

## Completing the claim form

- Please complete clearly in block capitals
- Please use a separate sheet to provide full details if necessary

## Section A - must be completed by the patient or patient's legal guardian

Insured person's/patient's family name:

Insured person's/patient's first name(s):

Correspondence Address:

Telephone number:

Email address:

Date of Birth (DD/MM/YY):

Membership number:

Group name (if applicable):

## Claim Details

1) Is this your first claim for this medical condition? Yes ☐ No ☐

2) Maternity Claim - Estimated delivery date:

Was the pregnancy the result of IVF? Yes ☐ No ☐

3) Please describe the medical symptoms or event you wish to claim for:

4) Diagnosis (if known):

5) Date you first noticed the symptoms?

6) Are you injured or ill as a result of an accident, (e.g. a road accident or an accident at work)or are you considering making a personal injury claim against someone else? Yes ☐ No ☐

7) Do you have any other insurance for this type of claim? Yes ☐ No ☐

8) Please list below the invoices for which you are claiming

| Dates of treatment | List of expenses for which you are claiming | Currency and amount paid | Who would you like us to pay | Preferred currency (we will do our best to oblige) |
|---|---|---|---|---|
| | | | | |
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## Payment Details:

Bank transfers are the quickest and safest method of payment. To enable us to pay the settlement directly into your account please give us the:

Account number*

Account holder(s) name(s):

Bank code**:

SWIFT/BIC code:

Sort Code:

IBAN number*:

Bank name:

Branch name:

Bank address:

Bank country:

* Please provide IBAN number for all bank accounts in EURO countries, for all other countries please provide a national account number

** Bank Codes are required in the following listed countries: Australia:BSB, Canada:CACPA, Denmark:BBC, Hong Kong: HKNCC, New Zealand: NZNCC, Singapore: IGB Sort Code, UK:SORT CODE, USA:ABA

## Section B - must be completed by the treating doctor

This section is only admissible if it is completed by the specialist or referring doctor who is registered and licensed to practice in the country where you receive treatment. We reserve the right to withhold benefit for treatment by doctors who do not hold internationally recognised qualifications and training (for example, a medical school listed in the World Health Organisation's World Directory of Medical Schools).

9) Please give description of symptoms:

10) Diagnosis

11) The date of onset:

12) Please tell us when the patient first consulted a doctor for this or similar symptoms:

13) Has the patient received any treatment, had any need for treatment or required medication and/or advice for this condition in the past 2 years? Yes ☐ No ☐

14) If the answer to Question 13 is yes, please provide details

15) To whom are you referring this patient? (if applicable)

Name:

Specialisation:

16) Date referred (DD/MM/YY):

17) What is the likely treatment plan and procedure to be performed?

18) If Medication has been prescribed, please provide details:

19) Hospital admission must be pre-authorised by us.

Name of hospital:

Proposed admission date:

Address of hospital:

Expected hospital stay (if known length of stay):

20) **Declaration:**
I hereby certify that I am the patient's doctor.
*Signature:*

Date (DD/MM/YY):

Telephone number:

Email address:

Name and Address

Practice stamp

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## Section C - Dental claims - must be completed by the treating dentist.

This section may only be completed by a dentist who is trained, qualified, and licensed to practice dentistry by the licencing authority of the country in which you receive treatment.

21) Treatment date (DD/MM/YY):

22) Prior to this visit, has the patient attended a dental inspection within the last 12 months?
Yes ☐ No ☐

If yes, please confirm the date:

If yes, was all work required at this appointment concluded?

23) What treatment has been received by the patient this visit?

24) Has all necessary treatment concluded? If not please list planned treatment.

If this is a claim for restorative treatment after an accident, we will write to you requesting the information we need.

25) Signature of dentist.

Date (DD/MM/YY):

Telephone number:

Email address:

Name and Address

Practice stamp

## Section D - Optical claims - must be completed by the patient or patient's legal guardian

26) Has your prescription changed since your last eye test? Yes ☐ No ☐

27) Please provide your current prescription:

| Rx | Sphere | Cylinder | Axis | Prism | Add |
|---|---|---|---|---|---|
| Right (OD) | | | | | |
| Left (OS) | | | | | |

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## Important Claim Information - please read

- You must get our pre-authorisation before making certain claims. Please refer to your membership guide
- You must send us the claim form within 6 months of the start of the treatment
- We recommend that you phone us before you start any treatment, so we can confirm the extent of your cover and help guide you through the claims
- Please complete a separate claim form annually for each unrelated medical condition and for each insured person
- Where an excess or co-insurance applies we will deduct this from any settlement due and show the calculations in our letter to you
- Please provide us with your email address. This will reduce any delay in corresponding with you and also allow us to keep you updated with the progress of your claim.

RELEASE OF MEDICAL INFORMATION
Expacare Limited (the "Company") together with its medical service and evacuation service suppliers ("Partners") needs your authority for release of medical information about you. In addition, in certain circumstances, we may be requested by your employer (where it meets the cost of your insurance) or to any insurance broker (lawfully appointed by you or your employer) to provide information about your claim. We always ensure that any information we supply to any third party is proportionate and relevant to the claim which we, as the insurance provider, are administering. We will not provide information which is not appropriate or relevant to the claim we are administering.

AUTHORISATION
I hereby authorise any doctor of medicine, hospital or other person who has attended or examined me, to furnish the Company and or its Partners, any and all information with respect to sickness or injury, medical history, consultation, prescriptions, or treatment and copies of all hospital and medical records. This information is required by the Company and its Partners in order to confirm coverage for my medical condition and proposed treatment. Further, I authorise and request that the Company provide such information to my employer (if appropriate) that is pertinent and relevant to its role as the policyholder that meets the premium for the insurance by which you are protected and to which the claim relates.

INSURED MEMBERS DECLARATION
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 as or in part, the policy will be invalidated and I will be liable for prosecution. I authorise and herewith agree that Expacare may forward data obtained from the claim form to the Insurer or its authorised Claims Administrator as the Insurance Company or any Reinsurer for the purpose of assessing the risk and handling the reinsurance.

I have read and understood the membership guide ☐

I have read and understood the important claim information ☐

Signature:

Date (DD/MM/YY):

**ALL sections must be completed.**
Failure to do so will delay the assessment of your claim

**CHECKLIST:**

**Have you signed the Declaration?** ☐

**Have you completed Section A?** ☐

**Have you completed Section D?** ☐

**Has your treating doctor/dentist completed and signed Section B/C?** ☐

**Have you enclosed itemised Invoices (together with proof of payment) for expenses that you are claiming for?** ☐

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