Claim Form

Please return this completed claim form, along with supporting data to:

Generali Assistance and Service Centre
PO Box 306, 266 Elmwood Avenue, Buffalo NY 14222
Tel: +1 905 532 3648 | Fax: +1 905 762 5194
Email: claims@generalihealth.com

INSTRUCTIONS: Please complete all sections in full. Any claim form which is incomplete cannot be processed and will be returned for completion. A separate claim form is required for each individual making a claim. **Please remember** to submit this claim form together with original copies of all supporting invoices and documents. Claims should be submitted to us within the time period specified in your policy, otherwise they will not be considered eligible for payment or reimbursement.

USE THE CHECKLIST BELOW TO ENSURE:

- ☐ All receipts, invoices, prescriptions, and referrals are attached
- ☐ The claim form is completed in full
- ☐ The declarations are signed and dated
- ☐ The diagnosis has been confirmed and is either stated on the claim form or on the invoices

Member ID Number	Group Name	Group Number

SECTION A - POLICYHOLDER DETAILS

Title:	☐ Mr.	☐ Mrs.	☐ Ms.	☐ Miss	☐ Other	Date of Birth
First Name			Surname			
Address						
Town/City	State/Province/Territory/Region		Country		Postal Code/Zip Code	
Email Address				Telephone Number (including area code)		

SECTION B - PATIENT DETAILS

Is the patient the policyholder stated above?	☐ Yes	☐ No	If no, please provide details:		
Title:	☐ Mr.	☐ Mrs.	☐ Ms.	☐ Miss	☐ Other	Date of Birth
First Name			Surname			
Patient's relationship to policyholder:	☐ Spouse	☐ Child	☐ Other:		Pre-Authorisation Number (if applicable)	

SECTION C - CLAIM DETAILS

In what country did the treatment take place?			
Is this claim resulting from an accident or work-related illness/ injury?	☐ Yes	☐ No	If yes, please provide details:
Do you hold any other insurance policy (i.e. car insurance) which provides you with cover in relation to this accident/injury?	☐ Yes	☐ No	If yes, please provide details of the insurer and your policy number:
Are you filing a claim or lawsuit against a third party, including an insurance company, to recover costs incurred as a result of this accident/injury	☐ Yes	☐ No	If yes, please provide the details of the third party concerned:

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PLEASE COMPLETE ALL PARTS OF THE FOLLOWING TABLE WITH THE DETAILS OF EACH INVOICE/RECEIPT, MAKING SURE TO INCLUDE THE AMOUNT CHARGED

Claim 1	Provider's Name		
Date of Service	Amount Charged	Currency of Bill	Has this bill been paid to you? ☐ Yes ☐ No
Nature/Reason of Treatment		Description of Expense	
Date first symptoms appeared		Date the first time you saw a doctor or received treatment for this condition/illness/injury:	
Details of any previous treatments for this condition/illness/injury			

Claim 2	Provider's Name		
Date of Service	Amount Charged	Currency of Bill	Has this bill been paid to you? ☐ Yes ☐ No
Nature/Reason of Treatment		Description of Expense	
Date first symptoms appeared		Date the first time you saw a doctor or received treatment for this condition/illness/injury:	
Details of any previous treatments for this condition/illness/injury			

Claim 3	Provider's Name		
Date of Service	Amount Charged	Currency of Bill	Has this bill been paid to you? ☐ Yes ☐ No
Nature/Reason of Treatment		Description of Expense	
Date first symptoms appeared		Date the first time you saw a doctor or received treatment for this condition/illness/injury:	
Details of any previous treatments for this condition/illness/injury			

Claim 4	Provider's Name		
Date of Service	Amount Charged	Currency of Bill	Has this bill been paid to you? ☐ Yes ☐ No
Nature/Reason of Treatment		Description of Expense	
Date first symptoms appeared		Date the first time you saw a doctor or received treatment for this condition/illness/injury:	
Details of any previous treatments for this condition/illness/injury			

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SECTION D- CLAIM REIMBURSEMENT DETAILS

Who should the payment be made to? ☐ Payment to medical provider (e.g. hospital, specialist) ☐ Payment to policyholder	Payment Currency: ☐ Currency of Claim ☐ Currency of Policy ☐ Other
Preferred Payment Method: ☐ Cheque ☐ Bank Transfer	If bank transfer, indicate the curency of the account:

NOTE: Due to possible restrictions in the country where your bank is located in - additional information may be required to facilitate payment OR the requested method of payment may not be available. To view the list of countries where payment restrictions apply, please refer to the resource section of the Generali Mobile Health website. It is recommended that you verify your account information with your bank and confirm that the currency selected will be accepted by your bank prior to submitting your claim.

FOR BANK TRANSFERS, PLEASE PROVIDE BANK DETAILS BELOW AND ENSURE THAT YOUR BANK ACCOUNT SUPPORTS THE CURRENCY CHOSEN

Name of account holder as it appears on your bank statement (e.g. John Smith)	Bank Account Number
Account Type: ☐ Chequing ☐ Savings	IBAN (applicable for all EUR payments) or IFSC (applicable for all INR payments to India)
Swift Code	Bank Code (includes MFO for Belarus [BYR], BSB for Australia [AUD])
Sort/Branch Code	Routing Number (includes ABA for United States [USD])
Tax ID (where applicable)	Additional Information (includes National Clearing Code for South Africa [ZAR])
Name of Bank/Financial Institution	Telephone (including area code)
Address	

Town/City	State/Province/Territory/Region	Postal Code/Zip Code	Country

INTERMEDIARY BANK DETAILS (where applicable)

Name of Intermediary Bank/Financial Institution	Swift Code
Account Number	Bank Code
IBAN	Telephone (including area code)
Address	

Town/City	State/Province/Territory/Region	Postal Code/Zip Code	Country

If you are aware of any additional information required in order to process international transactions within your country (e.g. Agency Code, Tax ID), please list below:

SECTION E- USING YOUR PERSONAL INFORMATION

The personal information that you supply to us and to any third parties acting on our behalf may be used for a variety of reasons. For example: to administer the claim and the insurance policy; to arrange for medical treatment; to calculate the premium payable by the policyholder; to complete returns required by our regulators and to deal with any complaints. We are also required to review the information that we hold for the purposes of crime prevention and compliance with international sanctions. We may share your information with, and obtain information about you, from other parties who are involved in the provision of services relating to the insurance policy. For example: companies providing administration, claims and medical services on our behalf. We may transfer information between countries and to countries outside the European Union. Where we transfer information to countries which may not have the same level of data protection as the European Union we will put a contract in place to ensure your information is protected. If you require any further information please contact: The Data Protection Officer, Assicurazioni Generali S.p.A., 100 Leman Street, London E1 8AJ, UK

CONSENT TO USE PERSONAL INFORMATION: I consent to the processing of my personal information by Assicurazioni Generali S.p.A. and by any other party acting on its behalf.

SPECIFIC CONSENT TO USE MEDICAL INFORMATION: I authorise Assicurazioni Generali S.p.A. and any other party who is involved in the provision of services relating to the insurance policy to seek any medical information relating to myself or my dependants that is required for administering the insurance policy. I also authorise any doctor, dentist, hospital, laboratory and other provider of dental, healthcare or medical services to provide full information relating to myself in accordance with the rules relating to access to medical reports or any similar legislation.

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SECTION F- PATIENT SIGNATURE AND RELEASE OF MEDICAL RECORDS

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, intentionally exaggerated or if fraudulent means/devices have been used by me or my dependants or anyone acting on my or their behalf to obtain benefit under my policy, Assicurazioni Generali S.p.A. will not pay any benefits for that claim. The amount of any claim settlement made to you, before the fraudulent act or omission was discovered, will become immediately due and owing to us. If the contract is rendered void due to false, fraudulent, intentionally exaggerated claims or if fraudulent means/devices have been used, premium will not be refunded, in part or in whole, and any pending claims settlements will be forfeited. In the event of fraudulent claims, the contract will be cancelled from the date of discovery of the fraudulent event and I may be liable to prosecution.

In respect of any medical claim, I hereby authorise my general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Assicurazioni Generali S.p.A. or their agents or other representatives.

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

Patient Signature (Parent/Guardian if claim is for a minor)	Date

Section G and H are to be completed by the treating doctor in BLOCK CAPITALS unless your invoice(s) contain details of the diagnosis as well as the nature of your treatment

SECTION G- MEDICAL PROVIDER'S DETAILS

Name of Doctor/Specialist	Qualifications/Credentials

Name of Hospital/Clinic

Address

Telephone Number (including area code)	Fax Number (including area code)

Email Address

APPLICABLE TO PHYSIOTHERAPY/PSYCHOTHERAPY CLAIMS ONLY. PLEASE PROVIDE REFERRAL DETAILS:

Name of Referring Physician	Date of Referral
Email Address	**Telephone Number (including area code)**

SECTION H- MEDICAL DETAILS

Indicate type of condition: ☐ Acute ☐ Chronic ☐ Acute episode of chronic	Date of onset of illness/symptoms	Date first consulted for illness/symptoms

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

Has the patient suffered from this condition previously? ☐ Yes ☐ No If yes, when?	Are you aware of any treatment given for this or any related illness in the past? ☐ Yes ☐ No If yes, please provide details:

Is it likely to reoccur? ☐ Yes ☐ No	Does it need rehabilitation? ☐ Yes ☐ No	Is it permanent? ☐ Yes ☐ No	Does it need long term monitoring, consultations, check-ups, examinations or tests? ☐ Yes ☐ No

APPLICABLE TO MATERNITY CASES ONLY

Estimated Date of Delivery	Is the pregnancy a result of assisted conception/infertility treatment? ☐ Yes ☐ No	If yes, please provide details:

APPLICABLE TO DENTAL TREATMENT CASES ONLY

Was the patient suffering from dental pain at the time he/she visited you for treatment? ☐ Yes ☐ No If yes, please provide details:

PLEASE SIGN AND AUTHENTICATE WITH AN OFFICIAL STAMP

Physician Signature	Date

Official stamp of Medical Provider

Email Form

Print Form