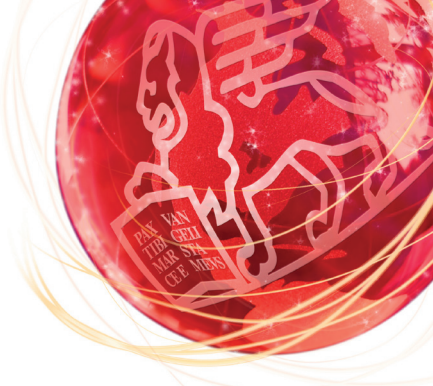
Generali Mobile Health Plan Claim Form



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. **Please remember:** if you seek medical services that require pre-authorisation (e.g. hospital admissions, outpatient surgery, etc.) and fail to obtain such authorisation from us prior to incurring expenses, you will be responsible for paying 25% of the eligible costs incurred in addition to any element of co-insurance.

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

USE THE CHECK LIST BELOW TO ENSURE:

- ❑ All receipts, invoices and prescriptions 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:

1 POLICYHOLDER DETAILS

Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Other Date of Birth: M M D D Y Y

First Name: Surname:

Address: City:

State/Province: Country: Postal Code:

Telephone:

Email Address:

2 PATIENT DETAILS

Is the patient the policyholder stated above? ❑ Yes ❑ No If no, please provide patient details:

Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Other

First Name: Surname:

Patient's Relationship to Policyholder: Date of Birth: M M D D Y Y

Pre-Authorisation Number (if applicable):

3 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 e.g. 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 third party concerned:

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 by you?**
MM/DD/YYYY			
Nature/Reason of Treatment		Description of Expense	
If this is an ongoing condition, please answer questions below			
Date symptoms first appeared:	MM/DD/YYYY	Date the first time you saw a doctor or received treatment for this condition/illness/injury:	MM/DD/YYYY
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 by you?**
MM/DD/YYYY			
Nature/Reason of Treatment		Description of Expense	
If this is an ongoing condition, please answer questions below			
Date symptoms first appeared:	MM/DD/YYYY	Date the first time you saw a doctor or received treatment for this condition/illness/injury:	MM/DD/YYYY
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 by you?**
MM/DD/YYYY			
Nature/Reason of Treatment		Description of Expense	
If this is an ongoing condition, please answer questions below			
Date symptoms first appeared:	MM/DD/YYYY	Date the first time you saw a doctor or received treatment for this condition/illness/injury:	MM/DD/YYYY
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 by you?**
MM/DD/YYYY			
Nature/Reason of Treatment		Description of Expense	
If this is an ongoing condition, please answer questions below			
Date symptoms first appeared:	MM/DD/YYYY	Date the first time you saw a doctor or received treatment for this condition/illness/injury:	MM/DD/YYYY
Details of any previous treatments for this condition/illness/injury:			

4 CLAIM REIMBURSEMENT DETAILS

Please select who payment should be make 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

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 bank account holder as it appears on your bank statement (e.g. John Smith):

Account Number:

Swift/BIC Code:

IBAN (where applicable):

Sort/Branch Code (where applicable):

Name of Bank:

Bank Address: City:

State/Province: Country: Postal Code:

Intermediary Bank Details (where applicable)

Name of Intermediary Bank:

Swift Code of Intermediary Bank:

Intermediary Account Number:

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:

5 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.

6 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: M M D D Y Y

Sections 7 and 8 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.

7 MEDICAL PROVIDER'S DETAILS

Name of Doctor/Specialist:

Qualifications/Credentials:

Name of Hospital/Clinic:

Address:

Telephone Number: Fax:

Email:

Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details:

Name of Referring Physician:

Telephone Number: Date of Referral: M M D D Y Y

8 MEDICAL DETAILS

Indicate Type Of Condition: ❑ Acute ❑ Chronic ❑ Acute Episode of Chronic

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

On what date did the patient first present these symptoms to you? M M D D Y Y

On what date would the first onset of symptoms have been apparent to the patient? M M D D Y Y

Has the patient suffered from this condition previously? ❑ Yes ❑ No If yes, when? M M D D Y Y

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 re-occur? ❑ 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 cases of pregnancy only

Estimated Date of Delivery: M M D D Y Y

Is birth of a single baby expected? ❑ Yes ❑ No

If you answered **No** to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? ❑ Yes ❑ No

If yes, please provide further details:

Applicable to dental treatment claims only

Was the patient suffering from dental pain at the time he/she visited you for treatment? ❑ Yes ❑ No

Please sign and authenticate with an official stamp.

Doctor's signature

Date: M M D D Y Y

Official stamp of Medical Provider