# HEALTH INSURANCE CLAIM FORM

REGENCY
for expats

- If you are claiming for: **Outpatient doctor visits / Medications / Dental / Laboratory tests**
  *Complete Parts 1 and 2 yourself and sign the declaration. Your attending physician must also complete Part 3. You do not need the doctor to complete Part 3 if you submit a bill or receipt showing the diagnosis and a breakdown of each item being billed.*

- If you are claiming for: **Inpatient, Emergency, Surgical treatments**
  *Complete Part 1 and 2 yourself and sign the declaration. Your attending physician must also complete Part 3.*

**Email your completed claim form along with all receipts, referral letters and medical reports (where applicable) to: claims@regency-ga.com**

## PART 1 (To be answered by member or parent if the patient is a minor)

### Policy/Member Information

| | |
|---|---|
| Patient Name | Policy Number |
| Policyholder Name | Member Number |

### Contact Details

| | |
|---|---|
| Address | Country |
| | Email |
| | Telephone |

### Reimbursement Information (Claims reimbursements are made by bank transfer)

| | |
|---|---|
| Reimbursement Currency | Account Number |
| Bank Name | Sort Code |
| Bank Address | IBAN Code |
| Account Name | BIC (Swift) Code |

## PART 2 (To be answered by member or parent if the patient is a minor)

### If this claim pertains to an illness

Making a fraudulent statement on this form is a criminal offence that will be reported to government agencies

1. When was the onset of the signs and symptoms?
2. When did you first consult a doctor about this problem or these symptoms?
3. What was the diagnosis, and recommended treatment including medication?
4. Have you ever had a similar illness or symptoms? If yes, please give full details including date of first onset.
5. Please state brief history of any Chronic Conditions including maintenance medications taken.

### If this claim pertains to an accident

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6. Date, time and exact place of accident.
7. Briefly describe how this accident occurred.
8. Was a third party involved? ☐ No ☐ Yes

If yes, please describe their part in this accident, and state whether reimbursement/compensation will be provided.

## Declaration

I hereby declare that all information provided on this form and the documents submitted herewith is true and correct to the best of my knowledge and belief. The amounts claimed are actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source. I certify; that premium payment for this policy was made with my authority and knowledge, that I am authorised to make the premium payment in the manner conducted, that I have received and accept the policy wording and policy documentation for this contract of insurance, and that I am in receipt of this policy in return for said premium payment.

Signature of Member (Parent if minor)

| | (DD/MM/YYYY)
Date

## Authorisation for Release of Information

I authorise any doctor, hospital, or other health provider or facility or reinsuring company, or employer to release to the Insurer ("the Company") any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefor. If this claim related to an accident, past or present, I also authorise any governmental body, agency, or other person or organisation who may have records pertaining to such accident to release such records or information. I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except reinsuring companies or other persons or organisation(s) performing business or legal services in connection with my claim, save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Signature of Member (Parent if minor)

| | (DD/MM/YYYY)
Date

## PART 3 (Ask your doctor to complete this section)

Patient Name

1. State briefly the nature of the illness or injury.

2. When did the symptons first arise?

3. On what date did the patient first consult you for this condition? | | (DD/MM/YYYY)

4. Had this patient ever suffered from this condition before?

☐ No ☐ Yes (please explain)

5. Has the patient ever had any similar condition or related symptoms before this incident?

☐ No ☐ Yes (please explain)

6. Does the patient have any existing condition(s) that may have caused, contributed to, or exacerbated this condition?

☐ No ☐ Yes (please explain)

7. Is this related to any accident or injury, or in any way connected with the patient's employment or work?

☐ No ☐ Yes (please explain)

8. Please provide full reports including but not limited to past medical history, referral letters, investigative procedures, and treatments.

9. (Claims for surgery) In addition to information in (8) above, please provide name and date of surgical procedure(s), operation notes, pathology report, and discharge summary.

10. (Claims involving pregnancy) Please state approximate commencement date of pregnancy or date of Last Menstrual Period:
| | (DD/MM/YYYY)

### Attending Physician Details

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Attending Physician Name

Address

Country

Email

Telephone

Physician's Signature. Official Stamp

| | (DD/MM/YYYY)
Date

**Please submit a separate form for each condition claimed.**