Insured by

UNIVERSAL LIFE

Re-Insured by

AXA

# MultiCare International Health Plan

## Claim Form

- You must fully complete sections 1, 2, 3 and 4.
- Your medical practitioner must fully complete sections 5, 6, and 7 in full.
- Both you and your medical practitioner must sign and date this form and it must be accompanied by original receipted and numbered invoices, payment receipts and prescriptions or it may not be processed.
- You must provide your menbership and Passport/ID number in order for us to process your claim.

**If you have any questions regarding this form or any other aspects of your cover, please telephone on: +357 22 88 22 22 – ask for the Accident & Health Department.**

### 1. Subscriber's and patient's details

| | |
|---|---|
| Name of subscriber | Passport/ID number |
| Membership number from your card | Group number (if applicable) |
| Name of patient | |
| Subscriber's date of birth | Patient's date of birth |

### 2. To be completed by patient (or subscriber if patient is under 18 years of age)

**1. If payment is to be made to someone other than the subscriber (eg. the patient's guardian) please complete the following:**
I authorise benefit to be paid directly to:

| | |
|---|---|
| Address | |
| Signature of subscriber | Date |

**2. Payments will be made in Euros unless we agree otherwise in writing.**
In which currency was the treatment originally billed?

| | |
|---|---|
| Name and telephone number of patient's family doctor | |
| Account number | Sort code |
| Name of account holder | Bank |

**3. If treatment was received outside Cyprus, you must answer the following questions:**

| | | |
|---|---|---|
| (a) Country where treatment took place | | |
| (b) The reason for the patient being abroad | | |
| (c) Dates of departure and return to own area of cover | from | to |

| | | |
|---|---|---|
| **4. Are you claiming cash benefit for in-patient treatment?** Please tick ✓ | Yes ☐ | No ☐ |
| If yes, please enclose a copy of your admission and discharge forms from the hospital. | | |

## 3. Other insurer's details

| | | |
|---|---|---|
| Is the treatment accident-related? Please tick ✓ | Yes ☐ | No ☐ |
| Is it covered under another insurance policy? Please tick ✓ | Yes ☐ | No ☐ |
| If you have answered 'Yes' to either of these questions, please give the name of the insurance company involved | | |

## 4. Patient's Declaration and Consent (to be completed by Patient)

We would like to inform you that the personal data which you shall provide to us by completing this form, concerning you and any members of your family who are covered by the MultiCare International Health Plan, are being collected by Universal Life in accordance with the purposes mentioned in the Consent For Processing of Personal Data that you have given when you envolled in the MultiCare International Health Plan. Specifically, the collection of the aforementioned data under this form is done for the purposes of:

1. Deterring any illegal claim and/or fraud where the same person claims compensation twice from two different insurance companies.
2. Collecting evidence (verified and numbered invoices and prescriptions) for the purpose of processing the claim. Universal Life may not be in a position to settle a claim if it lacks adequate information relating to the patient and does not have the patient's signature.
3. Correct internal administration and operation of the Company as well as confirmation of the cover. Otherwise Universal Life may not be in a position to settle a claim if it lacks knowledge as to who is the patient or as to where the treatment was administered.
4. Confirmation as to whether the illness, accident, hospitalization etc for which the claim is submitted by the patient is covered by the Multicare International Health Plan.

To fulfil the above mentioned purposes, on some occasions it is essential to obtain an additional medical report from your doctor, in addition to the information that your medical practitioner has completed in the Medical Section (Section 6) of the Claim Form. By virtue of the above Law, you have the following rights:

You may:

1. refuse to give your consent to the release of this medical report. In that case please note ✓ in the box ☐. Nevertheless, in that case and despite our reasonable efforts, please be informed that we may not be in a position to deal with your claim without the submission of this report.
2. request to read the report prior to this being sent to us by your doctor. In that case please note ✓ in the box ☐ and we will notify your doctor accordingly.

   Your doctor shall not send your report to us, until you have read it and consented to its contents. If you do not agree with its contents then you can again refuse to have it sent to us. Nevertheless, we may not be in a position to deal with your claim without this report.

Where, apart from the above report, it is absolutely necessary for us to discuss further your illness and the details of your treatment with your doctor in order to fulfil the above purposes, we shall not communicate with your doctor unless you give us your written consent for this. If you do not give us your consent by virtue of this document, you have the right to give your consent by virtue of another document which will be sent to you by Universal Life.

### Patient's declaration and consent

I declare that I am the patient, parent or guardian of the patient (if the patient is under 18 years of age) (please cross out what is not applicable).

I wish to claim benefit and declare that all the particulars I have given are to the best of my knowledge, true and correct. In order that my claim may be assessed and settled I hereby consent to Universal Life processing the personal data which I have included in this form and in any medical reports that may be submitted on my behalf to Universal Life with my consent.

I consent and authorise my doctor to discuss my illness and the details of my treatment with Universal Life.

I agree that one copy of this consent document will have the validity of an original.

| | |
|---|---|
| Signature – To be signed by the patient concerned (parent/guardian if under 18) | Date |

Send this claim form together with supporting material to:

**Accident & Health Department, Universal Life, P.O Box 21270, 1505 Nicosia, Cyprus**

## 5. Direct Settlement by Universal Life

**In-patient treatment must be pre-authorised by Universal Life (see your handbook for details). You must contact us on +357 22 88 22 22 or by fax on +357 22 88 22 66 at least 10 days before treatment to arrange this.**

**The claim form must be submitted within 90 days of the start date of the treatment along with all original and numbered receipts/ invoices – as per the policy membership agreement. Claims will not be considered if not submitted within 90 days of treatment being received. The issue of this form does not imply any liability on the part of Universal Life and/or AXA Global Healthcare (UK) Limited on behalf of AXA PPP healthcare. We recommend you photocopy the completed form and any enclosures for your own records.**

## 6. Medical Section (To be fully completed by patient's Medical Practioner – all boxes must be completed in block capitals please. We will require evidence of any diagnostic tests undertaken and we may require the results of those tests. We will ask you if we do.)

| | | |
|---|---|---|
| 1. Please give details of the symptoms presented | | |
| 2. Please give the date your Patient **first** became aware of **any** signs or symptoms of the conditions being claimed for (day, month & year) | Date | |
| 3. Please give the date on which your Patient **first** consulted any Medical Practitioner for this condition | Date | |
| 4. Please give a full history of the medical condition requiring treatment including full details of any previous investigation/treatment together with relevant dates | Dates | |
| 5. Have you referred the patient for any diagnostic procedures? If so please give details | | |
| 6. Please give the **exact** diagnosis (after all diagnostics have been completed) | | |
| 7. Please give details of any current and/or further treatment planned | | |
| 8. Drugs/other items prescribed (Please list) | Number of tablets/volume of liquid prescribed | Period covered by medication |
| 9. Name of patient receiving treatment (Please print) | | |

## 7. Hospital or clinic information (To be completed by medical practitioner)

| | | |
|---|---|---|
| Hospital or Clinic name and address | | |
| Admission/treatment date | Surgery date (if any) | Anticipated discharge date |

## 8. Medical practitioner declaration

I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct

| | |
|---|---|
| Name of Medical Practitioner (Please print) | Practice stamp |
| Signature | |
| Date | |

| For Universal Life Only |
| --- |
| Claim user |
| Supervisor |
| Medical adviser |
| Manager |
| Final decision |
| Comments on payment |

Insured by

UNIVERSAL LIFE

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