OPTIMUM GLOBAL
INTERNATIONAL INSURANCE SOLUTIONS

CLAIM FORM

The insured member is required to complete the following claim form and attach all the original medical bills and supporting documentation when filing the claim. A separate claim form must be completed for each medical condition, each currency and each member. All sections must be completed.

Personal Data provided in this claim form or submitted as part of this claim will be used and processed by us in line with our Privacy Policy which can be found on our website, or which can be requested from us at any time.

SECTION A: PATIENT DETAILS TO BE COMPLETED BY INSURED MEMBER

Name of Main Applicant: _____ Membership No.: _____ Date of Birth: _____ Sex: _____

Name of Patient (If other than the main Applicant): _____ Membership No.: _____ Date of Birth: _____ Sex: _____

Present Contact Address: _____

Telephone number: _____ Email Address for Remittance Advice: _____

SECTION B: SETTLEMENT DETAILS

We settle all eligible claims by bank transfer (EFT), therefore it is important that you confirm your correct bank details every time you make a claim. Should the incorrect bank details be provided we reserve the right to charge an administrative fee to cover any charges incurred due to the error.

Total amount claimed (including currency): _____

Currency of Reimbursement: _____

Bank Transfer – **All fields in the box below are MANDATORY. If the account holder is not the claimant then you must state their relationship with the claimant and provide evidence of their permission for the funds to be transferred to their account (except in the case of a minor):**

Name of Account Holder (as it appears on bank statement): _____

IBAN where applicable _____
(only if IBAN not applicable then full bank account number acceptable)

Account Holder address (residential address registered with the bank): _____

_____

Name of Bank, Branch and Location: _____

Swift Code/BIC: _____ Sort Code (for UK banks only): _____

PLEASE NOTE:

- **Bank charges may apply when making bank transfers.**
- **Payments are not made directly to any clinic, physician or medical provider.**
- **If IBAN numbers are not used please ensure that the account number is entered and that the Swift Code/BIC is also completed.**

DECLARATION & AUTHORISATION

(This part must be signed by the patient or patient's parent/legal guardian if the patient is below 18 years of age)
I hereby authorise any hospital, physician, person or organisation to disclose all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I certify that the above statements and answers are true and complete to the best of my knowledge and belief.

Signature of Main Applicant _____ Date _____ Signature of Patient _____ Date _____

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SECTION C: PATIENT DETAILS TO BE COMPLETED BY TREATING DOCTOR

Note: If there are multiple doctors, this section is to be completed by the last attending physician.

Patient's Name: Membership number:

1. Diagnosis (BLOCK CAPITALS PLEASE)

2. What was the date of the first consultation?

3. Please specify onset date of symptoms:

4. Date Treatment received:

5. Nature of Treatment:

6. Name of Physician/Surgeon and Qualifications:

Contact No. and Email:

Signature of Physician/Surgeon: Date: