HEALTH INSURANCE CLAIM FORM

To help us provide you with a fast and efficient service, we kindly ask you to consider the following:
- Please complete the front page of this form and ask your treating doctor/therapist to complete page 2; read page 3 carefully.
- All documents or invoices should preferably be issued in English, German, French, Dutch or Spanish and must use Arabic numerals and Latin characters (1,2,3… /a,b,c…).
- We recommend that you keep copies of all documents submitted.
- Finally, we kindly ask that you complete this form in block capitals and post it to the address mentioned above.

Note: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, with intent to mislead, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

A. Policyholder – Insured Details

Insurance number C29847423	First name(s)/surname/title Rita Tania	
Date of birth 1984-12-7	Correspondence address Toronto Marine HCC – MIS Group Box No. 2005	
Postcode and town Farming Hills, MI 48333-2005	Country and region Canada Toronto	
Phone (+country code and local dialling code) +1 123456789	Fax (+country code and local dialling code) +1 123456789	Email Rita@sample.com

B. Patient Details

Insured's or co-insured's number +1 123456789	First name(s)/surname/title TOM Steam
Date of birth 1956-10-17	Claim related to an accident? ☑ yes ☐ no

In case of an accident, please indicate how it occurred:

Third-Party Actions

Negligence of other drivers (abrupt lane changes) tailgating)

cyclist error (jaywalking, sudden movement)

C. Reimbursement

Currency of payment: Lorem ipsum

Payment method: ☐ Payment by cheque ☐ Payment via bank account

Account holder (if not identical with insured person): Lorem ipsum dolor sit amet,

Bank name Lorem ipsum	Country name Canada	Postcode 59-3656
Branch code (BLZ, ABA, sort code) 243234	Account no. 3453656	
BIC/SWIFT code 345345	IBAN 156768	

D. Patient's Signature and Release

I hereby certify that to the best of my knowledge this claim form does not contain any false, misleading or incomplete information. I understand and accept that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for legal action. 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 Globality S.A. or their appointed representatives. If a minor was treated, a parent or guardian should sign this section.

Rita Tania
Patient's signature

2023/12/09
Date (dd/mm/yyyy)

To be completed by treating doctor/therapist in block capitals

Patient name
Lorem ipsum

E. Medical provider/therapist information

Name of doctor/specialist		Qualifications/credentials
Lorem ipsum dolor sit		Lorem ipsum dolor sit
Name of hospital/clinic		
Lorem ipsum dolor		
Address		
Lorem ipsum dolor sit amet, consectetuer adipisc		
Postcode and town		Country and region
Lorem ipsum dolor sit amet,		Lorem ipsum dolor sit
Phone (+country code and local dialling code)	Fax (+country code and local dialling code)	Email
+1 123456789	+1 123456789	doctor@sample.com

F. Medical Information

Has confirmation of coverage been sent? ☑ yes ☐ no

Indicate type of treatment received ☑ Elective ☐ Emergency, date (dd/mm/yyyy) _____

Has treatment been received for a similar illness before?
Please indicate first date: Lorem ipsum dolor sit amet, consectetuer adipisc

Please provide full details of the medical condition requiring treatment, including the ICD code 9 or 10 (International Classification of Disease)

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Bob samen — Doctor's signature and stamp

2023/12/19 — Date (dd/mm/yyyy)

Exemption from the duty to maintain confidentiality

By signing the first page of this Health Insurance Claim Form, you make the following declaration: I am furthermore aware that, in order to assess the obligation to pay benefits, the insurer and the assistance companies/Service Centres commissioned by the insurer also check information that is provided by me to justify any claims, or which arises from the documents submitted by me (e.g. invoices or prescriptions), as well as from communications from a hospital or from members of a medical profession occasioned by me. For this purpose, I also grant exemption from the duty to maintain confidentiality to the members of medical professions or hospitals named in the submitted documents or involved in the treatment. Thus in this context, the submission of a claim for benefits constitutes an exemption from the duty to maintain confidentiality for the single instance in question. I also grant exemption from the duty to maintain confidentiality for the examination of claims in the event of my death. The exemption from the duty to maintain confidentiality, in order that claims may be verified, also extends to the staff of other health and accident insurers or assistance and service companies, who may be questioned regarding the insurance policies existing there, or the cases handled there. I am also making this declaration on behalf of my insured children, as well as the insured persons legally represented by me, who are themselves not capable of appreciating the significance of this declaration.

Owing to special statutory regulations, members of medical professions or hospitals in individual countries demand a separate declaration regarding exemption from the duty to maintain confidentiality. In these countries, this is the prerequisite for Globality S.A. and the assistance companies commissioned by Globality S.A. to assist you when making a benefit claim (e.g. arrangement of direct payment, transfer to a suitable hospital). In these cases, you will be sent the appropriate documents and requested to provide your signature.

What must be done when an insured event occurs?

We naturally wish to settle all claims as quickly as possible, also in your best interests. For this purpose, claims for insurance benefits must be asserted and the relevant invoices submitted as soon as the treatment is ended.

a) First of all, it is important for you to know that we are only obliged to indemnify you when we have received all the invoices and documents requested by us; these invoices and documents become our property and we reserve the right to archive them.

b) Please note the following points:
Send your invoices and documents directly to your relevant Service Centre (unless we have agreed otherwise in a particular case). You will find the respective contact details on the first page of this Health Insurance Claim Form.

   - Always hand in original documents in conformity with the respective legal regulations for invoices typical of the country concerned. We may request that you prove to us that you have already paid the doctor's bill, for instance. In cases in which the chemist or pharmacy keeps the original invoice or prescription, we would like to ask you to send us a copy verified by stamp and signature of the chemist or pharmacy.
   - If another health insurer or other institution has reimbursed part of the costs, it will be sufficient to send us duplicates of the invoice documents with the other insurer's or institution's original confirmation of reimbursement.
   - We may also pay benefits to the person or party ringing or sending the required documents, with the effect of having discharged our obligation.

c) Claims for insurance benefits may be neither assigned nor pledged. Exceptions see below (Special service).

How are your expenses reimbursed?

Benefits can be paid according to the principle of reimbursement. In other words, in these cases we will reimburse the eligible costs incurred within the framework of medical treatment. If you wish a direct settlement of the costs please contact our Service Centre. You will find the contact details on the first page of this Health Insurance Claim Form.

a) Our reimbursement can be paid out to you:
You or the insured person are the contractual partner of the doctor/therapist consulted. When treatment commences, the doctor/therapist will conclude a contract for treatment with you or the insured person as the basis on which he/she can subsequently draw up an invoice. That invoice must then be sent to your relevant Service Centre so that the contractually agreed benefits can be paid out to you from there.

b) Special service:
As a special service at your request, your relevant Service Centre can pay the reimbursement directly to the party issuing the invoice, for instance if particularly large sums are involved (over € 2,000). Please contact your relevant Service Centre in order to agree a direct settlement procedure.

c) If you require in-patient treatment, we will always try to settle the costs directly with the hospital. In-patient treatment costs, such as the rate for nursing care or the surcharge for hospital accommodation or the fee for transport by ambulance, can be paid directly to the party issuing the invoice. In addition, you may also assign your entitlement to reimbursement from us to the party providing the treatment or services, for instance by signing a so-called declaration of assignment for the hospital. However, we can only pay the costs directly if the hospital agrees to this procedure and if this is in keeping with the customs typical of the country concerned.

In which currency are your expenses reimbursed?

Invoices are reimbursed in the agreed currency. Foreign-currency costs are converted into the contractual currency at the actual rate applicable on the day on which we receive the documents, namely the official exchange rate of the Federal Reserve System (Fed) for the agreed contractual currency. Currencies which are not traded and for which reference rates are not defined are similarly converted at the current rate specified by the Federal Reserve System (Fed), unless you can submit bank vouchers proving that you purchased the necessary currency at a less advantageous rate in order to pay the invoices.

How can you contact your relevant Service Centre?

You can contact your relevant Service Centre at any time, day or night. Addresses, telephone numbers and email addresses are stated on the first page of this Health Insurance Claim Form. If you or an insured person contact your relevant Service Centre following the occurrence of an insured event, we will offer to call you back immediately.

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Note: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, with intent to mislead, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

A. Policyholder – Insured Details

Insurance number	First name(s)/surname/title	
C29834567	Nelson	
Date of birth	Correspondence address	
1989-11-12	Lorem ipsum dolor sit amet, consectetuer	
Postcode and town		Country and region
Lorem ipsum dolor sit amet,		Lorem ipsum dolor sit amet,
Phone (+country code and local dialling code)	Fax (+country code and local dialling code)	Email
+1 123456789	+1 123456789	Nelson@sample.com

B. Patient Details

Insured's or co-insured's number	First name(s)/surname/title
+1 123456789	TOM Steam
Date of birth	Claim related to an accident?
1956-10-17	☑ yes ☐ no

In case of an accident, please indicate how it occurred:

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C. Reimbursement

Currency of payment: Lorem ipsum

Payment method

☐ Payment by cheque ☐ Payment via bank account

Account holder (if not identical with insured person): Lorem ipsum dolor sit amet,

Bank name	Country name	Postcode
Lorem ipsum	Canada	59-3656

Branch code (BLZ, ABA, sort code)	Account no.
243234	3453656
BIC/SWIFT code	IBAN
345345	156768

D. Patient's Signature and Release

I hereby certify that to the best of my knowledge this claim form does not contain any false, misleading or incomplete information. I understand and accept that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for legal action. 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 Globality S.A. or their appointed representatives. If a minor was treated, a parent or guardian should sign this section.

Nelson

Patient's signature

2023/10/11

Date (dd/mm/yyyy)

To be completed by treating doctor/therapist in block capitals

Patient name
Lorem ipsum

E. Medical provider/therapist information

Name of doctor/specialist		Qualifications/credentials
Lorem ipsum dolor sit		Lorem ipsum dolor sit
Name of hospital/clinic		
Lorem ipsum dolor		
Address		
Lorem ipsum dolor sit amet, consectetuer adipisc		
Postcode and town		**Country and region**
Lorem ipsum dolor sit amet,		Lorem ipsum dolor sit
Phone (+country code and local dialling code)	**Fax (+country code and local dialling code)**	**Email**
+1 123456789	+1 123456789	doctor@sample.com

F. Medical Information

Has confirmation of coverage been sent?	Indicate type of treatment received
☑ yes ☐ no	☑ Elective ☐ Emergency, date (dd/mm/yyyy) _____

Has treatment been received for a similar illness before?
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Please provide full details of the medical condition requiring treatment, including the ICD code 9 or 10 (International Classification of Disease)

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Bob samen — 2023/10/23

Doctor's signature and stamp — Date (dd/mm/yyyy)

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