health program medica supports life

CLAIM FORM
MEDICA POLICY

PART A – To be completed by the Policy Owner (for an Individual Policy) or the Main Insured (for a Group Policy) and the Insured Patient

Policy Owner's Name: _____ Policy No.: _____

Main Insured's Name (only where policy is a Group Policy): _____

Policy Owner/Main Insured's Tel. No: _____ Policy Owner/Main Insured's email: _____

Insured Patient's Details

Full Name: _____

Telephone No.: _____ Date of Birth: _____ Identity Card No.: _____

Information for the Illness/Injury

Illness/Injury (Describe): _____

Describe the symptoms: _____

When did the symptoms first appear: ___ /___ / ___

When did the Accident occur (if applicable): ___ /___ / ___

Did you ever receive any medical treatment in the past for the same illness/accident: ☐ YES ☐ NO If YES when?: ___ /___ / ___

Name and Address of attending Doctor: _____

Name and Address of Clinic/Hospital: _____

Date of Admission: ___ /___ / ___ Date of Discharge: ___ /___ / ___ Date of Surgical Operation (if applicable): ___ /___ / ___

Submission of Claim Prior to Receiving the In-Hospital Treatment

Do you wish your Claim to be investigated prior to receiving the In-Hospital Treatment? ☐ YES ☐ NO

- The examination of your Claim may be done only for a scheduled In-Hospital Treatment based on the information provided to us.
- To enable us to examine your request you must submit the Claim Form along with all necessary supporting documents, at least five (5) working days prior to the scheduled In-Hospital Treatment.
- Our decision will be based solely on the terms and conditions of your Insurance Policy and will not in any way be considered as an indication or advice for the necessity of the recommended treatment.

Settlement of Claim Payment

Please select:

☐ Payment to the Policy Owner/Main Insured on the basis of the original receipts which are attached. In case you have submitted your claim prior to the In-Hospital Treatment and we have approved it, the receipts should be sent to Mednet after the completion of the Treatment.

☐ Cheque payable to the Doctor or the Clinic/Hospital where the Treatment has taken or will take place. In case you have submitted your claim prior to the In-Hospital Treatment and we have approved it, the invoices have to be sent to Mednet after the completion of the Treatment.

It is noted that for outpatient cases all the original receipts should be attached.

Other Insurance Covers

If the Treatment creates an obligation for compensation from a third party or is covered by any other source (Private or Social Insurance, Health Funds, etc) please give details:

_____

_____

Declaration

I hereby declare that all the information I have given for this claim, is true and complete.

Full Name & Signature of Insured Patient*: _____

**To be signed by the Parent/Legal Guardian of any Proposed insured under 18 years old.*

Full Name & Signature of Policy Owner (for Individual Policy) or Main Insured (for Group policy):

_____

Date: _____ Place: _____

For the faster processing of your claim, please ensure that all fields of the Claim Form are completed and accompanied by all required supporting documentation. Following completion of your form, please send this to Mednet at fax number 22519819. For any assistance you may require, please contact Mednet at 22463033.

Processing of Special Categories of Personal Data

For the purposes of examining and executing your claim submitted herewith (the "Claim"), as well as for the purposes of ensuring compliance with the terms of the policy for which you are an insured person ("the Policy"), we will be required to process special categories of data ("Sensitive Data"). The processing of Sensitive Data refers exclusively to your health information as an insured person and is limited to information that is necessary for the examination and execution of the Claim and/or for the evaluation of your adherence to the terms of the Policy.

Further to the information you have provided us with, and where you have also provided us with the relevant authorization, processing shall include communication with the relevant attending physicians and with the hospitals/clinics for the purpose of obtaining clarification and further information and/or Medical Exams.

Recipients of Sensitive Data are relevant members of our staff and the staff of Mednet S.A. (the independent health claims administrator with which we collaborate) as well as our, relevant to your claim, associates/partners, that are subject to an obligation of confidentiality. The recipients of your Sensitive Data may also be the Policy Owner if this is a different person.

Please note that you have the right to withdraw your consent to the processing of your Sensitive Data at any time. In such a case however, we may not be able to process your Claim. Further information on your rights with regard to your personal data, as well as with regard to the processing of your data by us, can be found in our Privacy Statement that is available on our website www.eurolife.com.cy.

With your signature below, you hereby give explicit consent to the processing of Sensitive Data (that is, data relating to your health) for the above mentioned purposes.

Full Name & Signature of Insured Patient*: _____

** To be signed by the Parent/Legal Guardian of any Insured Patient under 18 years old.*

Identification No.: _____ Date: _____ Place: _____

Authorisation

With the present, I hereby consent to and authorise Eurolife Ltd and/or the independent health claims administrator Mednet S.A. to refer to the hospital/clinic where I have been treated or will be treated for the medical condition for which I have submitted a claim, in order to receive information and copies (in paper and/or digital format) of the following personal data:

- Any data and information that relates to the medical condition for which a claim has been submitted, including any copies of medical reports and medical diagnostic exams and their results.
- Any detailed analysis or other information in relation to the medical hospitalisation expenses for which the claim is submitted.

In addition I authorise the hospital/clinic in which I have been treated or will be treated for the medical condition for which a claim is submitted, to supply to Eurolife Ltd and/or the independent claims administrator Mednet S.A., with the original and/or copies of the above mentioned data.

In addition I hereby consent to and authorise my doctor, the hospital/clinic and/or the diagnostic centre, to provide any clarification or further information that may be requested from the relevant staff members and medical associates of Eurolife Ltd and the independent claims administrator Mednet S.A, in relation to my medical condition, its treatment, the details of my hospitalisation, and any other medical results and/or diagnostic exams, as well as medical expenses that relate to my claim.

The photocopy of this authorisation shall be considered as an original.

Full Name & Signature of Insured Patient*: _____

**To be signed by the Parent/Legal Guardian of any Insured Patient under 18 years.*

Important Note: We would like to inform you that you may at any time revoke the above authorization by contacting Eurolife Ltd and/or Mednet S.A. In such a case and in order for us to be able to complete the examination of your claim, you will have to arrange to obtain the data requested and submit this to us directly. Please note that in the event that there is insufficient information with regard to your claim, we will not be able to satisfy your claim.

PART B - To be completed by the attending Physician
Patient's Information

Full Name of Patient: _____ Date of Birth: _____

Illness/Injury

Initial Diagnosis (date and detailed description)

Final Diagnosis (date and detailed description)

Treatment

☐ Urgent Incident ☐ Outpatient ☐ Daily Surgical Treatment

☐ Scheduled surgical operation ☐ Other

Date of operation: ___ /___ / ___

Name & Address of Hospital/Clinic where Treatment has been/will be undertaken: _____

_____

Date/Time of Admission: ___ /___ / ___ _____ am/pm

Date/Time of Discharge: ___ /___ / ___ _____ am/pm

Details of Illness/Injury

Describe the Patient's symptoms: _____

_____

When did the Patient's symptoms first appear? (date): ___ /___ / ___

When did the accident occur?: ___ /___ / ___
(If applicable/ date)

When did the Patient first visit you? (date): ___ /___ / ___

State and describe in detail the causes which have led to the submission of the Patient to the Hospital/Clinic:

_____

Medical and diagnostic laboratory examinations which have been performed with regard to the illness/injury (state dates and attach the results):

_____

Describe the treatment which was given to the Patient as well as the medicines which have been administered to date: _____

_____

Treatment to follow: _____

_____

Is the patient under medical observation or is receiving treatment from any Doctor of other specialty (Give details): _____

_____

Has the Patient recovered from the illness/injury?: _____

Medical History

Is this the first time the Patient is receiving treatment for this illness/injury? ☐ YES ☐ NO

If not, when did the first incident occur and how was it treated? _____

_____

Does the Patient suffer or suffered in the past from any illness or any other disease or syndrome? (Describe): _____

_____

Attending Physician's Declaration

I hereby declare that to the best of my knowledge and belief, the answers to the above questions are complete and accurate.

Physician's Full Name: _____ Specialty: _____

Address: _____

Telephone: _____

Physician's stamp and signature: _____ Date: _____

Stamp of Hospital/Clinic: _____

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