

InterGlobal HealthCare Plans

Claim Form

for Medical Treatment Reimbursements

Date stamp (for office use only)

Please complete clearly in block capitals. Information about how to complete can be found on the reverse of this form. Please call us Toll Free: 0120-76-7703 or email japan-claims@interglobal.co.jp if you require any further assistance.

Send your claim to: Claims Team, InterGlobal Japan Limited, 3F Koike Koraibashi Bldg., 1-3-4 Koraibashi, Chuo-Ku, Osaka, 541-0043, Japan
 W www.interglobalpmi.com

A Patient details

If the patient is a dependant under the age of 18, the main member must complete sections A to G for the patient.

Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/>	Other:
Family name:	First name(s):
Date of birth (dd/mm/yy):	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Group name (if applicable):	
Member number:	Plan number:
Correspondence address:	
Town:	Postal code:
Country:	Email:
Daytime telephone:	Fax:
Evening telephone:	
Symptoms/condition needing treatment:	

B Main member details (if different from section A Patient details, above)

Family name:	First name(s):
Member number:	Plan number:

C Further information

Does the patient have another insurance policy that covers medical costs? Yes No If yes, please provide details on a separate sheet.

If you have suffered an injury as the result of an accident, are you claiming from a third party? Yes No If yes, please provide details on a separate sheet.

Is your claim as a result of an accident? Yes No

If yes, please provide the circumstances of the accident and how it happened on separate sheet.

D Hospital cash benefit

Are you claiming hospital cash benefit? Yes No

If yes:

- Please send us the original admission and discharge form from the hospital where the treatment was provided

E Claim details

Date of treatment	Invoice date	Invoice reference	Amount (including currency)

F Medical Information

1. Contact details

Please provide details of the medical practitioner/specialist/consultant/therapist who treated you:

Name:	
Telephone:	Fax:
Address:	

2. Symptoms

Please provide full details of the symptoms needing treatment:

On what date did you first notice these symptoms? Date (dd/mm/yy):

Are your symptoms a result of an accident?

 Yes

 No

If yes, please provide full details below (please note we may contact you for further information if required):

On what date did you first present these symptoms to your medical practitioner? Date (dd/mm/yy):

Have you suffered from the same or similar symptoms before?

 Yes

 No

If yes, please provide complete current and previous history including dates:

3. Investigations requested

If you underwent diagnostic procedures or tests, e.g. CT scans or blood tests please detail which procedures were performed and their results:

Please detail all medications prescribed (if you were provided with a sheet detailing the medication from your pharmacist, please attach a copy to this claim form):

4. Diagnosis

Diagnosis of medical condition, if known:	ICD10 code:
What is the underlying cause of the condition:	

Was the medical condition as a result of an accident?

 Yes

 No

Was the member under the influence of alcohol, drug or any other intoxicating substance at the time of the accident?

 Yes

 No

Treatment proposed:

Is a follow-up visit needed?

 Yes

 No

If yes, when (dd/mm/yy)?

5. Maternity treatment

Is the pregnancy a result of infertility treatment/medication, including conception by artificial means?

 Yes

 No

If yes, please provide method of conception:

G Signed declaration

I declare that all the details given on this claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I am committing a criminal offence and that this will invalidate the plan and make me liable to prosecution. For this medical claim I authorise any medical practitioner, specialist, consultant, therapist or other relevant establishment who has attended me/the patient in the past or is attending me/the patient at present, to give any details that may be asked for by the insurer or authorised administrator. I confirm and agree that any personal information collected or held by the insurer or authorised administrator, whether given in this form or collected in any other way, may be used by the insurer or authorised administrator, or disclosed to or transferred to any organisation for the purpose of i) assessing this claim and giving ongoing insurance cover, customer service and the processing of future claims, ii) processing and making payments, and iii) within the limits of relevant consents, providing marketing communications in respect of the insurer, its related products and services and those of its associated companies. I understand that InterGlobal Insurance Company Limited may use organisations who may be located in the EEA or elsewhere. Where an organisation is located outside the EEA, InterGlobal Insurance Company Limited will take all necessary steps to ensure the organisation provides appropriate guarantees in respect of their technical and organisational security measures and the transfer and processing complies with all relevant data protection and privacy laws.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, (on behalf of myself and any family members specified in this form) for InterGlobal Insurance Company Limited to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members.

Our full terms and conditions and details of our privacy policy can be found at www.interglobalpmi.com

Patient's / member's signature:	Date (dd/mm/yy):
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Important information

You must submit original itemised invoices to support your claim. A copy of your prescription should also be provided.

Please make sure that all invoices show all of the following details:

- Claimant's name
- Date of service
- Diagnosis
- Itemised charges

Please remember these important points when completing your claim form:

- Assessment of your claim may be delayed if you do not complete all the necessary sections of this form
- Complete one form per medical condition, per person
- Return this form to us within six (6) months of first treatment date. Travel claims must be received within 31 days.
- Always send us the original invoices with this form. Photocopies, receipts and credit card statements will not be accepted
- If you were provided with a sheet from your pharmacist detailing prescribed medication, please attach a copy to this claim form
- We will not refund non-medical costs such as medical reports unless explicitly requested by us. Depending on the condition/loss, we may require further medical, dental, or police reports
- Most mobile phone email addresses cannot receive attachments. Please provide a PC email address if possible.

Section A

If the patient is a dependant under the age of 18, the main member must complete the form and sign the declaration for them.

If the patient is under 18 and has their own plan, a parent or legal guardian must complete the form and sign the declaration for them.

Section D

You can claim hospital cash benefit if you have stayed overnight in hospital and the hospital has not charged you or any other party for treatment. Please see your plan guide and table of benefits for more information on hospital cash benefits.

Section G

If the declaration has not been read and signed, we will not be able to process your claim.

No claims discount

Applies to individual and family plans only and NOT group plans.

Please note: By making this claim you will affect your no claims discount.

Excess

If you have an excess on your plan, this will be deducted as per the excess on your plan from any reimbursement.

Checklist

Have you sent us:

- A fully completed claim form with signed and dated declaration?
- Original itemised invoices (copies will not be accepted)?
- Original hospital admission and discharge form if claiming hospital cash benefit?
- A copy of prescribed medication's description and instruction sheet.

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Policy number:	<input type="text"/>
Member number:	<input type="text"/>
Claim number:	<input type="text"/>

H Payment details

Have you personally had to pay costs for the treatment that you are claiming for?

Yes No

If yes, and you are personally seeking reimbursement, please tell us how you wish to be reimbursed (please tick one):

<input type="checkbox"/> 1. Credit Card. Please complete this information for credit card payments.	Currency of credit card:
<input type="text"/>	Expiry Date (mm/yy) <input type="text"/>
Name (as it appears on card):	Card Type:
<input type="checkbox"/> 2. Bank transfer. Please complete this information for bank transfer payments:	
Name of your bank:	Account number:
Address of your bank:	
Name of account holder:	BIC (swift code):
Bank sort code (if applicable):	IBAN (if applicable):
Currency of bank account:	Routing code (if applicable):
<input type="checkbox"/> 3. Foreign draft. Please specify currency:	
<input type="checkbox"/> 4. Cheque in the currency of your plan.	

Important information

If you are not personally seeking reimbursement we will pay the treatment provider direct, as long as the payment instructions are shown clearly on the invoice. If you are personally seeking reimbursement, you need to tell us how you wish to be reimbursed.

- i) Please ensure that you are able to receive payment in the method and currency you have requested. We reserve the right to pass on any payment charges incurred by us for cancelling the original payment or raising a new one.
- ii) We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details.
- iii) If you do not give us the IBAN or BIC, you may incur bank charges.
- iv) Payment by foreign draft in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft. We strongly recommend that, wherever possible, you choose to be reimbursed by credit card or bank transfer as these are the quickest and safest methods of payment.
- v) We can make payment in most readily traded currencies. In the event that we are unable to make payment in the currency you have specified, we will contact you to confirm an alternative currency.

We cannot make payment in the following currencies:

- Chinese yuan renminbi (RMB)
- Brunei dollars (BND)
- Venezuelan bolivares (VEB)
- Zimbabwean dollars (ZWD)
- Lebanese pounds (LBP)

If you do not specify a payment currency, we will pay your claim in the currency of your plan.

- vi) Please note we cannot make claim reimbursement payments via foreign draft or cheque to banks based in Qatar.
- vii) Please note we are unable to make claim payment reimbursements via bank transfer to Japan Post banks as they do not accept international remittances.
- viii) Japanese banks will often charge for processing a foreign draft or cheque. Most Japanese banks will not process foreign drafts or cheques in any currency other than Japanese yen.