LIVELIFE

HEALTH INSURANCE CLAIM FORM

REGENCY global assistance

If you are claiming for:

- **Outpatient doctor visits / Medications / Dental / Laboratory tests**
  Complete Parts 1 and 2 yourself and sign the declaration. Your attending physician must also complete Part 3. You do not need the doctor to complete Part 3 if you submit a bill or receipt showing the diagnosis and a breakdown of each item being billed.
- **Inpatient, Emergency, Surgical treatments**
  Complete Part 1 and 2 yourself and sign where indicated. Your attending physician must also complete Part 3.

All claims are subject to assessment in accordance with policy terms and conditions. Any indication as to eligibility given before such an assessment is issued subject to the final claim assessment.

Email your completed claim form along with all receipts, referral letters and medical reports (where applicable) to: Claims@Regency-GA.com

PART 1 (To be completed by a member or a parent if the patient is a minor)

Policy/Member Information

Patient Name

Policy Number

Member number

Contact Information for this Claim

Contact Name

Email

Relationship to the Patient

Telephone

Country

Reimbursement Information (Claims reimbursements are made by bank transfer)

Reimbursement Currency

Account Holder Name

Bank Name

Account Number

Bank Address

Sort Code

IBAN Code

BIC (Swift) Code

PART 2 (To be answered by member or parent if the patient is a minor)

If this claim pertains to an illness

It is very important this section is completed accurately. Failure to do so is criminal insurance fraud and will be reported to authorities.

1. What were the first symptoms you experienced?

2. When did you first experience them?

3. What is the diagnosis?

4. What treatment and medication did your Doctor prescribe?

5. Have you ever had a similar illness or symptoms?
☐ No ☐ Yes If yes, please give full details including date of first onset.

6. Please state brief history of any medical conditions including maintenance medications taken.

If this claim pertains to an accident

It is very important this section is completed accurately. Failure to do so is criminal insurance fraud and will be reported to authorities.

7. Date, time and exact place of accident. | | (DD/MM/YYYY)

8. Describe how this accident occurred.

9. Was a third party involved?
☐ No ☐ Yes If yes, please describe their part in this accident, and state whether reimbursement/compensation will be provided.
Remember to include an accident report with your claim.

Declaration

I hereby declare that all information provided on this form and the documents submitted herewith is true and correct to the best of my knowledge and belief. The amounts claimed are actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source. I certify; that premium payment for this policy was made with my consent, that premium payment was authorised, and that in return I have received and accept the policy wording and policy documentation for this contract of insurance. I understand that any previous indication I may have been given as to eligibility of this claim was issued subject to the final assessment of this claim, and I am submitting this claim form and associated documents to initiate the claims assessment in accordance with the terms and conditions of the policy. I understand that Regency may at its discretion recover any default or overdue premiums from claims. I accept liability for any costs to Regency relating to false or fraudulent claims, and/or costs relating to failing to observe the terms and condition of the policy. I understand that any false or fraudulent activity will be reported to law enforcement agencies, and will be disclosed by Regency as deemed appropriate to prevent and detect crime including insurance fraud.

Signature of Member (Parent if minor)

| | (DD/MM/YYYY)
Date

Authorisation for Release of Information

I authorise any doctor, hospital, other health provider or facility, reinsuring company, intermediary or employer to release to the Insurer ("the Company") any information or records they may have regarding my insurance, health, tests, treatments I have received, and benefits or compensation thereof. If this claim related to an accident, past or present, I also authorise any governmental body, agency, or other person or organisation who may have records pertaining to such accident to release such records or information. I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except reinsuring companies or other persons or organisation(s) performing business or legal services in connection with my claim, or my insurance policy save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Signature of Member (Parent if minor)

| | (DD/MM/YYYY)
Date

PART 3 (Ask your doctor to complete this section)

It is very important this section is completed accurately. Failure to do so is criminal insurance fraud and will be reported to authorities.

Patient Name

1. What is your diagnosis?

3. When did the symptoms begin? | | (DD/MM/YYYY)

3. What are the symptoms?

4. Is this a referral, if yes, please provide details of the medical professional who referred the patient.

☐ No ☐ Yes

5. What date did the patient first consult you for this | | (DD/MM/YYYY)

6. How long have you known the patient for?

7. Has this patient ever suffered from this/or a similar condition before?

☐ No ☐ Yes (please explain)

8. Does the patient have any underlying condition(s) that may have caused, contributed to, or exacerbated this condition?

☐ No ☐ Yes (please explain)

9. Is this related to any accident or injury, or in any way connected with the patient's employment or work?

☐ No ☐ Yes (please explain)

Medical Professional Declaration

It is very important this section is completed accurately. Failure to do so is criminal insurance fraud and will be reported to authorities.

I confirm my statements above are correct and I am willing to provide supporting documents on request.

Attending Physician Name

Address

Country

Email

Telephone

Physician's Signature. Official Stamp

| | (DD/MM/YYYY)
Date

Please submit a separate form for each condition claimed.