Archipelago
Life Insurance Limited

Claim form for medical treatment reimbursements

Please complete clearly in BLOCK CAPITALS. **Are you submitting this claim as a scanned copy?** ☐ **Yes** ☐ **No**

One form must be completed for each patient, for each medical condition treated.

Sections A to D and section F have to be completed by the patient, or the main member on behalf of the patient if the patient is a dependant under the age of 18. Section E has to be completed by the patient's medical practitioner, specialist or therapist, unless the claim is for a repeat prescription for medication to treat a chronic medical condition and we have previously approved and paid claims for the same medication to treat the same chronic medical condition.

Further information about how to complete this form can be found in the Claims procedures.

Failure to complete all sections of this form may result in delays.

Section A: Patient details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ Male ☐ Female
Member number:	Plan number:

Correspondence address:

Town:	Postcode:	Country:

Email:

Daytime phone: | Evening phone:

Section B: Main member details (if different from section A)

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

Section C: Claim details

Detail the symptoms/medical condition that the patient received treatment for:

Is this claim for a wellness checkup? ☐ Yes ☐ No If 'Yes', section E does not need to be completed.

If this claim is not for a wellness checkup, is it:
a new claim? ☐ Yes ☐ No If 'No', provide the previous claim number:
a claim for a repeat prescription? ☐ Yes ☐ No If 'Yes', section E does not need to be completed.

Is this a claim for hospital cash benefit? ☐ Yes ☐ No

If 'Yes', send us the original admission and discharge form from the hospital where the treatment was provided. Section E must also be completed by the medical practitioner or specialist.

If 'No', provide the breakdown of the invoices being submitted with this claim:

Date of treatment (dd/mm/yyyy)	Invoice date (dd/mm/yyyy)	Invoice reference	Amount (including currency)

Use a separate sheet if you need more space.

Does the patient have another insurance plan or policy that covers medical costs? ☐ Yes ☐ No

If 'Yes', provide the other insurer's details including the name of the insurer, the insurer's address and the patient's plan or policy number with that insurer:

Section C: Claim details (continued)

Is the claim as a result of an accident?	☐ Yes ☐ No
If 'Yes', provide the circumstances of the accident including how it happened, the location, the time and the date, using a separate sheet if you need more space:	
If the patient has suffered an injury as the result of an accident, are they claiming from a third party?	☐ Yes ☐ No
If 'Yes', provide the other insurer's details including the name and the plan number below:	

Section D: Data Protection and Declaration – the Declaration must be signed by the patient or the main member if the patient is a dependant under the age of 18

Data Protection Notice

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with the Personal Data Protection Act 2010.

We will use any personal data we collect about you and where appropriate, your dependants, to process your claims, administer your policy, detect and prevent fraud, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

The policyholder consents to the processing of the personal data provided to the insurer and the transfer of such personal data to other Archipelago Life Insurance Limited entities for the purposes of performance of the contract, such personal data shall be governed by the personal data protection laws of that country. The policyholder is responsible to ensure that all data provided to the insurer are accurate at all times and is obliged to inform the insurer of any changes.

Your information may also be used for the detection and prevention of fraud and for audit purposes. Archipelago Life Insurance Limited works with other insurance providers, regulatory bodies and law enforcement organisations to prevent and detect fraud.

We will not disclose any such information outside of the Company, including any third parties working on our behalf, except for fraud prevention purposes, and/or if required/obliged by law or governmental or judicial bodies or agencies or to our regulators under proper authority.

Your medical information will only be disclosed to those involved with your treatment or care, including your general practitioner/primary health physician, or to their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents.

We will communicate directly with you about your claim if you are aged 18 or over, or with the main member if you are under 18 unless we are advised otherwise. Claims information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information; or to another person that you have authorised us to provide such information.

If you want us to disclose your medical information to another individual or next of kin, please complete the section below.

I would like information about this claim to be provided to:

Name:	Relationship:

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 may be committing a criminal offence and that this may invalidate the plan and make me liable to prosecution. For this medical claim I authorise any medical practitioner, specialist, 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 any authorised administrator.

I confirm that I give explicit consent (on behalf of myself and any family members specified in this form) for Archipelago Life Insurance Limited to process our personal information with respect to our membership.

I authorise and request any hospital, specialist, physician or other health provider to furnish Archipelago Life Insurance Limited or its duly authorised agent acting on Archipelago Life Insurance Limited's behalf with such information as Archipelago Life Insurance Limited or such agent may seek from them in connection with any treatment or other services provided to me or my dependant/s for the purpose of Archipelago Life Insurance Limited considering this claim.

I do (not)* wish to see a copy of any medical report before it is sent to Archipelago Life Insurance Limited. (*Delete the word NOT if you wish to see a copy of the medical report before it is sent to Archipelago Life Insurance Limited).

Patient's/member's signature:
Date (dd/mm/yyyy):

Section E: Medical – must be completed by the medical practitioner/specialist/therapist

1. Contact and registration details

Name of medical practitioner/specialist/therapist: Qualifications:

Phone: Fax:

Email:

Date the patient first registered with you/the clinic/the hospital (dd/mm/yyyy):

2. Symptoms

a) Provide full details of the symptoms presented:

b) Has the patient suffered from the same or similar symptoms before? ☐ Yes ☐ No
If 'Yes', are the symptoms related to a previously diagnosed medical condition? ☐ Yes ☐ No
If 'Yes', specify the medical condition:

c) On what date did the patient first notice these symptoms (dd/mm/yyyy)?

d) On what date did the patient first present these symptoms to you (dd/mm/yyyy)?

3. Diagnosis

Diagnosis of medical condition, if known: ICD10 code:

Is there any underlying cause? ☐ Yes ☐ No
If 'Yes', provide details:

Is the medical condition as a result of an accident? ☐ Yes ☐ No
If 'Yes', was the patient under the influence of alcohol or any other intoxicating substance at the time of the accident? ☐ Yes ☐ No

Treatment proposed:

Investigations requested, if any:

In your opinion, is this condition: ☐ Acute ☐ Chronic ☐ Acute episode of a chronic condition

4. Type of complementary treatment recommended, if relevant:

☐ Physiotherapy ☐ Osteopathic ☐ Chiropractic ☐ Homeopathic ☐ Acupuncture ☐ Traditional Chinese medicine ☐ Podiatry
Number of sessions needed:

5. Referrals

a) Was the patient referred to you? ☐ Yes ☐ No
If 'Yes', please complete 'Section E: Medical (continued)' on the back page.

6. Hospital admission

Has the patient been admitted to hospital for this condition? ☐ Yes ☐ No
If 'Yes', provide the following details:

Admission date (dd/mm/yyyy): Discharge date (dd/mm/yyyy):

7. Declaration

I declare that to the best of my knowledge and belief the information I have given in the Medical section of this Claim form is full, true and complete.

Medical practitioner's/specialist's/therapist's signature:

Date (dd/mm/yyyy):

Practice stamp:

Section E: Medical (continued)

5. Referrals (continued)

Name of referring practitioner:	Date of referral (dd/mm/yyyy):
Qualifications:	Phone:

b) Have you referred the patient? ☐ Yes ☐ No

If 'Yes', provide the following details:

Name of specialist you referred the patient to:	
Date of referral (dd/mm/yyyy):	Phone:

If available, please provide a copy of the referral letters.

Section F: 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, you must tell us how you wish to be reimbursed by ticking either 1, 'Bank transfer' or 2, 'Foreign draft', and completing the required information.

We will only issue payment to:

- the patient if they are 18 or over;
- the planholder if the patient is under 18 and is a dependant under the plan; or
- the parent or legal guardian named as the planholder, if the patient is the main member and is under 18.

If another person or entity has paid on your behalf please give their name:

Failure to complete all information for the chosen reimbursement method may result in you, the named person or entity:

- experiencing delays in receiving the claim settlement; and
- incurring additional bank charges.

☐ 1. Bank transfer – this is the quickest and safest method of payment

Name of account holder:

If the patient's name (as given in section A) is different to the account holder name, please provide the following details:

Address of account holder:

Email address of account holder:

Telephone number of account holder:

Bank account details:

Bank name:

Bank address (including town and city):

BIC/SWIFT code:

Currency of bank account:

Account number:

To help us direct your payments efficiently, supply the following as relevant:

IBAN number (mandatory for all payments to bank accounts in countries that have adopted IBAN):

Sort code (mandatory for UK located banks):

Routing Code/Branch Code (as available):

ABA number (mandatory for transfers to US located banks):

☐ 2. Foreign draft

Name to appear on the draft:

Currency of the draft:

Checklist

There are two ways to send your claim to us:

1. By post – check you have included:

- a fully completed Claim form with signed and dated declarations ☐
- original itemised invoices ☐

Photocopies, receipts and credit card statements are not acceptable. We are unable to return original documents, but are happy to provide certified copies on request.

- an original hospital admission and discharge form if claiming hospital cash benefit ☐

2. By email – have you read the scanned claims acceptance criteria? ☐

You will find the criteria for accepting scanned claims in your Claims procedures or in the Members section at www.interglobalpmi.com

Please call us on +603 6201 0899 or email claims@archipelagolife.com if you require any further assistance.

Send your claim to: Claims Team, Archipelago Life Insurance Limited, B-08-07 Gateway Corporate Suites, Gateway Kiaramas, No 1 Jalan Desa Kiara, Mont Kiara, 50480 Kuala Lumpur, Malaysia. W www.archipelagolife.com F +603 62010481