

Please send claim form to:

Global Assistance & Healthcare PT  
Global Asistensi Manajemen Indonesia  
Graha Simatupang Tower 1D  
8th Floor, JL. Letjend. T.B.  
Simatupang Kav 38  
Jakarta 12540  
Indonesia

Phone: +62 21 788 39121  
Fax: +62 21 782 9332  
Email: expacare@global-assistance.net

## Claim Form

### Completing the claim form

- Please complete clearly in block capitals
- Please use a separate sheet to provide full details if necessary

### Section A - needs to be completed by the patient or patient's legal guardian

Insured person's/patients family name: \_\_\_\_\_

Insured person's/patients first name (s): \_\_\_\_\_

Nationality: \_\_\_\_\_

Date of Birth (DD/MM/YY): \_\_\_\_\_

Membership number: \_\_\_\_\_

Group name (if applicable): \_\_\_\_\_

Correspondence Address: \_\_\_\_\_

Is this a recent change of address: Yes  No

Telephone number: \_\_\_\_\_

Fax number: \_\_\_\_\_

Email address: \_\_\_\_\_

#### Claim Details:

1) Is this **you** first claim for this medical condition? Yes  No

2) Are **you** claiming for cash **benefit**? Yes  No

3) Please describe the medical symptoms or event **you** wish to **claim** for: \_\_\_\_\_

4) Diagnosis (*if known*): \_\_\_\_\_

5) Date you first noticed the symptoms? \_\_\_\_\_

6) Are **you** injured or ill as a result of an **accident**, (e.g. a road **accident** or an **accident** at work) or are **you** considering making a personal injury **claim** against someone else? Yes  No

7) Do **you** have any other insurance for this type of **claim**? Yes  No

8) Please list below the invoices for which you are claiming (Original invoices must be enclosed, not receipts or photocopies. We will keep these for audit purposes so please make copies for your records).

Dates of Treatment	List of expenses for which <b>you</b> are claiming	Currency and amount paid	Who would <b>you</b> like <b>us</b> to pay	Preferred currency ( <i>we will do our best to oblige</i> )
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Payment Details:**

Bank transfers are the quickest and safest method of payment.

To enable **us** to pay the settlement directly into **your** account please give **us** the:

Account number*:	Bank name:
Account holder(s) names(s):	Branch name:
Bank code**:	Bank address:
SWIFT/BIC code:	
IBAN number*:	Bank country:

\* Please provide IBAN number for all bank accounts in EURO countries, for all other countries please provide a national account number

\*\* Bank Codes are required in the following listed countries: Australia:BSB, Canada:CACPA, Denmark:BBC, Hong Kong: HKNCC, New Zealand: NZNCC, Singapore: IGB Sort Code, UK: SORT CODE, USA: ABA

**Section B - needs to be completed by the treating doctor/dentist**

This section is only admissible if it is completed by the **specialist** or referring **doctor** who is registered and licensed to practice in the country where **you** receive **treatment**. **We** reserve the right to withhold **benefit** for **treatment** by **doctors** who do not hold internationally recognised qualifications and training (for example, a medical school listed in the World Health Organisation's World Directory of Medical Schools).

9) Please give description of symptoms:

---

---

---

10) The date of onset and diagnosis:

11) Please tell **us** when the patient first consulted a **doctor** for this or similar symptoms:

---

---

---

12) Has the patient received any **treatment**, had any need for **treatment** or required medication and/or advice for this condition in the past 2 years?

Yes  No

13) If the answer to Question 12 is yes, please provide details

---

---

---

14) To whom are **you** referring this patient? (*if applicable*)

Name:

Specialisation:

15) Date referred (DD/MM/YY):

16) What is the likely **treatment** plan and procedure to be performed?

---

---

---

17) If Medication has been prescribed, please provide details:

---

---

**18) Hospital admission must be pre-authorized by us.**

Name of **hospital**:

Proposed admission date:

Address of **hospital**:

---

---

Expected **hospital** stay (*if known length of stay*):

---

---

**19) Declaration:**

I hereby certify that I am the patient's **doctor**.

Signature:

Date (DD/MM/YY):

Telephone number:

Fax number:

Email address:

Name and Address:

---

---

*Practice stamp*

**Dental claims**

This section may only be completed by a **dentist** who is trained, qualified, and licensed to practice dentistry by the licencing authority of the country in which **you** receive **treatment**.

20) Please provide the dental history for the last 12 months?

---

---

21) Date of last routine check up and was any treatment carried out?

---

22) Start date of treatment

---

23) End Date of treatment

---

24) What **treatment** has been received by the patient?

---

---

25) Has all necessary **treatment** concluded?  
If not please list planned **treatment**?

---

---

---

If this is a **claim** for restorative **treatment** after an **accident, we** will write to **you** requesting the information **we** need.

26) Signature of **dentist**:

---

Date (DD/MM/YY):

---

Telephone number:

---

Fax number:

---

Email address:

---

Name and Address:

---

---

---

*Practice stamp*

---

## Important Claim Information - please read

- **You** must get **our pre-authorisation** before making certain claims. Please refer to **your** membership guide
- **You** must send **us** the **claim** form within 6 months of the start of the **treatment**
- **We** recommend that **you** phone **us** before **you** start any **treatment**, so **we** can confirm the extent of **your** cover and help guide **you** through the claims
- Please complete a separate **claim** form for each unrelated medical condition and for each **insured person**
- Always send us original invoices with this form. Photocopies, receipts and credit card statements will not be accepted.
- Where an **excess** or **co-insurance** applies **we** will deduct this from any settlement due and show the calculations in **our** letter to **you**
- Please provide **us** with **your** email address. This will reduce any delay in corresponding with **you** and also allow **us** to keep **you** updated with the progress of **your** claim

### RELEASE OF MEDICAL INFORMATION

Expacare Limited (the "Company") together with its medical service and evacuation service suppliers ("Partners") needs your authority for release of medical information about you. In addition, in certain circumstances, we may be requested by your employer (where it meets the cost of your insurance) or to any insurance broker (lawfully appointed by you or your employer) to provide information about your claim. We always ensure that any information we supply to any third party is proportionate and relevant to the claim which we, as the insurance provider, are administering. We will not provide information which is not appropriate or relevant to the claim we are administering.

### AUTHORISATION

I hereby authorise any doctor of medicine, hospital or other person who has attended or examined me, to furnish the Company and or its Partners, any and all information with respect to sickness or injury, medical history, consultation, prescriptions, or treatment and copies of all hospital and medical records. This information is required by the Company and its Partners in order to confirm coverage for my medical condition and proposed treatment. Further, I authorise and request that the Company provide such information to my employer (if appropriate) that is pertinent and relevant to its role as the policyholder that meets the premium for the insurance by which you are protected and to which the claim relates.

### INSURED MEMBERS DECLARATION

I declare that to the best of my knowledge and belief, the information given on this form is true and complete. I understand and accept that in the event of this claim form being fraudulent in whole as or in part, the policy will be invalidated and I will be liable for prosecution.

I authorise and herewith agree that Expacare may forward data obtained from the claim form to DKV Deutsche Krankenversicherung AG/Germany or its authorised Claims Administrator as the Insurance Company or any Reinsurer for the purpose of assessing the risk and handling the reinsurance.

I have read and understood the membership guide

I have read and understood the important **claim** information

From time to time **we** might feel it is important to contact **you** with reference to newsletters, new offerings etc. Please tick if **you** agree to receive such information.

Signature: \_\_\_\_\_

Date (DD/MM/YY): \_\_\_\_\_

#### CHECKLIST:

**Have you signed the Declaration?**

**Have you completed Section A?**

**Has your treating doctor/dentist completed and signed Section B?**

**Have you enclosed itemised Invoices for expenses that you are claiming for?**

ALL sections must be completed. Failure to do so will delay the assessment of your claim