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Allianz

# TRAVEL INSURANCE CLAIM FORM FOR ACCIDENT AND SICKNESS

**INSTRUCTION**

1. This form is to be used when filing a claim for reimbursement of Medical Expenses.
2. Section A must be completed by the insured in full.
3. Following to be provided
   a) Section B to be completed by the attending physician.
   b) Itemized bills with : claimant's name / nature ofi llness / injury, summary of treatment and charge for each service.
4. This form must be signed and dated in all applicable sections.
5. This form and all attached bills must be submitted to the Policy issuance office.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of the conditions of the insurance contract.

Policy No : ATO/HO/08/0009 Plan : ..........................
Is International SOS Authorization obtained? ☐ Yes ☐ No If yes, SOS Case No : ..........................

## SECTION A

1. Name of Insured : ..........................
   Date of Birth : .......................... Gender: Male ☐ Female ☐
2. Name of Claimant : ..........................
   Claimant's Date of Birth : .......................... Gender: Male ☐ Female ☐
3. Current Residence Address and Tel. No: ..........................
4. Date of Arrival in Country : .......................... Date scheduled to return to Sri Lanka : ..........................
5. If Accident, provide details. i.e. how, when and where accident occurred : ..........................
6. If sickness, advice when and where symptoms first occurred : ..........................
7. Name and address of consulting physician (s) : ..........................
8. Have you ever been treated for this illness before ☐ Yes ☐ No
   If yes, provide name and address of treating physician (s) of first consultation
   ..........................
9. Provide Name and Address of your family doctor / specialist : ..........................
10. Please list name of medications you are presently taking : ..........................
11. Please furnish details of any Health insurance policy you are holding : ..........................

### Authorization

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agent group policyholder, insurance company, association-, -employer or benefit plan administrator to furnish to the insurance company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provide to, person whose death injury, sickness or loss is the basic of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payment under the Policy Number identified above. I authorize the group policyholder, employer or benefits plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

.......................... ..........................
Signature of claimant or Parent, if claimant is minor Date

I hereby certify that the above information is true and correct to the best of my knowledge and belief

.......................... ..........................
SIGNATURE Date