Mapfre Middlesea p.l.c.
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Registration Number: C5553

Health Insurance Claim Form

IMPORTANT NOTES

A referral by your General Practitioner prior consultations with specialists, therapists and any diagnostic procedures is recommended, except for consultations/treatment given by gynaecologists, paediatricians or ophthalmologists. You must always contact Mapfre Middlesea p.l.c. before receiving planned in-patient treatment, C.T./M.R.I. scan, to enable us to confirm eligibility and extent of cover. Claims, together with original receipts, to be submitted within 3 months of initial date of treatment.

1. INSURED/PATIENT'S DETAILS

Title:	
(Sur)name of policyholder:	
I.D. card no.:	Date of birth of policyholder:
Title:	
(Sur)name of patient:	
I.D. card no.:	Date of birth of patient:
Address:	
Tel/Mob. no.:	Policy no.:
E-mail:	
Group/Company name (if applicable):	

2. PAYMENT DETAILS - *Let us know your bank account details for processing of payment*

Use the bank details below for this and future claims YES ☐ | NO ☐
IBAN:
Account Holder Name:

3. TO BE COMPLETED BY THE PATIENT/LEGAL GUARDIAN

Reason for seeking medical advice:		
Date of patient's first visit to any doctor for this condition:		
Did treatment require in-patient treatment? YES ☐ | NO ☐		
If the answer is "YES" please advise:	Admission date:	Discharge date:
Attach hospital certificate(s) (if applicable):		
Are any of the costs recoverable from a third party? YES ☐ | NO ☐ If "YES", give details:		

4. TO BE COMPLETED BY A REGISTERED MEDICAL OR DENTAL PRACTITIONER

Patient's Name:

Details of the medical condition/symptoms:

Diagnosis:

Date of first consultation with the GP for this medical condition:

Treatment given:

Treatment recommended:

Does the patient require further treatment from a specialist? YES | NO

Date:

Name and Signature of General Practitioner:

5. TO BE COMPLETED BY A SPECIALIST

Name patient(s):

Details of the patient's complaints/symptoms:

Diagnosis:

Treatment given:

Treatment recommended:

Date:

Name and Signature of Specialist:

DECLARATION

I/We hereby declare that, after checking all details, the above information and statements are, to the best of my/our knowledge and belief, correct and complete. I understand that in the event of an incomplete and/or non-disclosure of material information, Mapfre Middlesea p.l.c reserves the right to repudiate the claim. Furthermore, I declare that I have not withheld any information relevant to the claim and assume full responsibility for the statements being made.

If the answers to all or any of the above questions have been written by others at my/our dictation or instruction I/We confirm that I/We have read those answers and that they are correct and that such person completing this form on my/our dictation or instruction for this purpose will be regarded as my/our agent.

I give explicit and unequivocal consent to Mapfre Middlesea p.l.c. to seek any information from any doctor, surgeon, hospital, clinic, laboratory or persons that have records or knowledge of my health in order for the validity of the claims to be established. I hereby authorise any doctor, surgeon, hospital, clinic, laboratory or persons that have records to provide full medical information concerning myself and my dependants.

Date:

Patient's signature (If the patient is under 18 years of age, then the legal guardian must sign):

DATA PROTECTION

Mapfre Middlesea p.l.c. is legally bound to follow the provisions of the Data Protection Act, 2001 Mapfre Middlesea p.l.c. is registered with the Office of the Commissioner for Data Protection to process data in accordance with this Act. The Data Protection Policy of Mapfre Middlesea p.l.c. is compliant with this Act, a copy of which is available on request.

HLTCF-V2.0-010823
COM. NO. MMS080523/1