MAPFRE MIDDLESEA

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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 ☐<br>If "YES", give details: | | |

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

Name patient(s):

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 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.I authorise MAPFRE Middlesea p.l.c. to share information with others (including insurers and Insurance Associations) in order to prevent fraudulent claims. I declare that all the answers given and the statements made are true and correct. Furthermore I declare that I have not withheld any information relevant to the claim. 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.

I give consent to MAPFRE Middlesea p.l.c. to process my personal data supplied by myself or any person, body or entity in order to process, handle and settle the claim.

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, 2018. If you require any further information about how MAPFRE Middlesea Plc processes your personal data, please follow this link www.middlesea.com/insurance-mt/data-protection/.

MAPFRE Middlesea p.l.c. (C-5553) is authorised by the Malta Financial Services Authority (MFSA) to carry on both Long Term and General Business under the Insurance Business Act. MAPFRE Middlesea p.l.c. is regulated by the MFSA.