

All claims under £125 or €/\$200 or HK\$1,500 per condition, please complete Section A, B and C and return this with the original receipt(s) showing the diagnosis and a full breakdown of costs for each condition being claimed for. ALL sections MUST be completed in full for hospitalisation claims and all claims over £125 or €/\$200 or HK\$1,500. A referral letter from **Your Specialist** should be attached when **You** are claiming for diagnostic tests or covered alternative **Treatments**.

Policyholder: Policy Number:

Section A: Patient's Details - To be completed by the member

Family Name: Address:
 First Name and Initials:
 Date of Birth: day month year Email:
 Contact Telephone Number: Fax/Mobile:
 Do **You** hold any other insurance? Yes No Were **Your** injuries caused by an **Accident**? Yes No
If Yes, please provide full details on a separate sheet *If Yes, please provide full details on a separate sheet*

Section B: Claims Settlement - To be completed by the member. It is essential that all information is completed if We are to complete an international transfer.

Total amount claimed, including currency of claim: Bank Name and Address:
 Currency in which **You** wish settlement to be made:
 State to whom **You** wish settlement to be made, if different to the member: Account Name/No./Sort Code:
 Address to where settlement to be sent: IBAN Code:
 BIC (Swift) Code: ABA Routing No. (USA Banks only):
 Correspondent Bank Details (if applicable):

- Please note payment may not have been credited to **Your** bank account at the time **You** receive **Your Advice** from Us. **You** will need to check with **Your** bank.
- If settlement is to be sent care of **Your** bank or by transfer, please give full details of **Your** bank opposite:

Section C: Declaration

"I declare that all information, to the best of my knowledge, provided on this Claim Form is truthful and correct. I also understand that this declaration gives permission to Goodhealth and their appointed representatives to approach any third party for information required to complete their assessment of this claim including, but not limited to, my current and previous **Medical Practitioners**."
 "I declare and agree that the personal information collected or held by Goodhealth, whether contained in this claims form or otherwise obtained may be used by Goodhealth, or disclosed to or transferred to any organisation within the Aetna Group (of Companies), their suppliers and partners, Worldwide for the purpose of 1) providing on-going insurance and customer service, 2) processing and giving effect to credit card payment, 3) generating statistics to provide marketing material in respect of insurance-related services of Goodhealth or it's associated companies and 4) processing claims or analysing the insurance."
 Patient's Signature: Date: day month year
(If patient is under 18 years of age, Parent or Guardian must sign)

Section D: Claims Information - To be completed by the Patient's Medical Practitioner or Dental Practitioner

Details of **Medical Condition** requiring **Treatment**: *(Please provide the precise diagnosis, if known)*
 Underlying cause:
 If this claim is for maternity please advise whether the pregnancy is as a result of any form of assisted conception:
 How long has this condition existed?
 When did the patient first become aware of any symptoms prior to seeking medical **Advice**?
 Date of first consultation with any practitioner for this condition:
 Has this, or any similar condition previously been suffered from?
 Please confirm the likely period of **Treatment** and prognosis (if known):
 Name and address of referring Doctor/Dentist:
Please complete only if the patient has been referred to you
 Please detail any diagnostic tests performed and attach the results:
This question relates to dental Treatment only Is this claim for a routine check-up? Yes No

If You have insufficient space in any section, please provide full details on separate sheet

Section E: Medical Practitioner or Dental Practitioner Details - To be completed by the patient's Medical Practitioner or Dental Practitioner

Name of Practitioner: Official Stamp
 Address of Practitioner:
 Tel: Fax:
 Email:
 Practitioner's Signature:
 Date: day month year

****IMPORTANT** - Please ensure**

- All original receipts and prescriptions are attached
- The Claim Form is completed in full
- The declarations are signed and dated
- All laboratory tests are attached
- The diagnosis and underlying cause have been confirmed

This will ensure that **Your** claim is reviewed in a timely fashion.

Important Note - Please ensure **Your** Claim Form is completed in full and returned within six months of **Your** initial **Treatment**. Failure to complete **Your** form in full will result in the form being returned to **You** and will hold up the processing of **Your** claim. Please note Goodhealth is not responsible for any costs associated with the completion of this form or for any further information/document requested by **Us** to assess **Your** claim. The issuing of this Claim Form is in no way an admission of liability.

Please ensure that all costs for non-Emergency **In-Patient/Day-Patient Treatment**, all MRI and CT scans, are agreed by **Us**, on **Our** Helpline or in writing (fax/email/letter) before any planned **Treatment** is undertaken. Planned **Treatment** undertaken without pre-authorisation from **Us** will not be covered. A verbal confirmation does not constitute pre-approval. If in doubt, please contact the Medical Helpline, as shown on **Your** Membership Card.

PLEASE NOTE: A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH CONDITION CLAIMED.

Planned In-Patient and Day-Patient Treatment

In the event of a planned admission on an **In-Patient** or **Day-Patient** basis to a **Hospital**, the following steps must be taken. Payment of all expenses incurred by **You** will not be recoverable unless **You** follow these procedures.

- i) Contact **Our** Medical Helpline as soon as reasonably possible prior to admission giving full details of the condition, proposed **Treatment** including dates and name of procedure (if known) together with the name of the **Specialist** and **Hospital** details. (The telephone number is provided on the back of **Your** membership card).
- ii) The Medical Helpline will advise **You** if they have sufficient information to confirm **Your** cover. If not, they will advise **You** what further information is required.
- iii) When sufficient information has been made available to appraise **Your** claim, the Medical Helpline will verbally confirm the basis of **Your** cover and will despatch written confirmation to **You**.

- iv) The Medical Helpline will attempt at all times to make arrangements with the **Hospital** for all eligible bills to be settled directly (under the International Healthcare Plan). Where this has been arranged, **You** should send the original Claim Form and any unpaid invoices (if given to **You** by the **Hospital**) to **Your** Goodhealth Claims Service.
- v) Please ensure a new/separate Claim Form for each member, each new **Medical Condition** and each admission to **Hospital** is submitted.

Out-Patient Treatment

If **You** receive medical **Treatment** as an **Out-Patient**, outside of **Our** **Provider Network**, **Treatment** must be paid for in full by **You** at the time of the appointment and re-claimed from **Us**. In such circumstances, please ensure that a Claim Form is completed by **You** and the **Medical Practitioner** or **Specialist**. Please remit this to **Your** Goodhealth Claims Service with all substantiating proof of **Your** claim, including, but not limited to, the original invoice(s) and proof of payment, prescription and a written diagnosis from the **Medical Practitioner**.

Please return **Your** Claim Form to:

HONG KONG for Asia and the Pacific Rim

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Admiralty Centre	T +852 2860 8000
18 Harcourt Road	F +852 2147 9960
Hong Kong	E claims@goodhealth.com.hk

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