International Healthcare

Claim For Reimbursement Of Medical Expenses

Medical Administrators International
Expatriates serving expatriates

For claims above € 500, US$ 675 or CHF 750
This form, duly completed and signed, should be returned to:

Medical Administrators International
Suite 1412-13, World Commerce Centre
11 Canton Road, Kowloon
Hong Kong
Tel: +852 3516 8181

For claims below € 500, US$ 675 or CHF 750
You can also send this form by:

1- Scan and email to: aplus@medical-administrators.com
2- Fax: +852 2529 9200

* Original invoices must be kept for a minimum period of 12 months. During this period, the Insurer reserves the right to ask for the original invoices at any time.

TO BE COMPLETED BY THE PATIENT

Policyholder / Employee

Pers. ref. no.: _____ / _____

Last Name : _____ First name : _____

Address : _____

Patient

Last Name : _____ First name : _____

Date of birth (d – m – y) : _____ Sex : ☐ M ☐ F

Relationship

☐ Self ☐ Spouse ☐ Child ☐ Secondary dependant

Is the claim covered by another insurance? ☐ Yes ☐ No

If yes, please specify the amount reimbursed. : _____

Specify by which insurance. : _____

Is this the result of an accident? ☐ Yes ☐ No
In case of accident, please complete the "Disability / Accident Claim Form I".

Amounts claimed per currency

Currency	Amount of expenses	Nature of expenses	Diagnosis	Date of 1st symptoms (d - m– y)	Date of 1st diagnosis (d - m– y)

Total: _____

Have you suffered from this or any related condition before? ☐ Yes ☐ No

If **yes**, please provide details separately.

Diagnosis and full details of prescribed medicines (name and dosage) must be stated on the original bill and the claim form.

Mode of payment

a) Reimbursement will be done by **cheque or bank transfer to your designated account**. Should you wish to modify instructions please contact us.

b) Reimbursement is done in the currency of the policy.

Hospitalisation

Date: _____

Diagnosis : _____

Treatment or operation : _____

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

I certify that I have been made aware of the obligation to respond to the above questions and understand that incomplete or inaccurate answers would lead to the application of the Insurance Code article L 113-8 (contract nullity) or L 113-9 (benefits reduction). I undertake to communicate to the insurer information about the proposed insured and his dependents in strict compliance of the legislation on the processing of personal data in force. This information may be disclosed to authorized professional bodies, as well as all those involved in the management and execution of this contract. I have, as well as the members of the contract, the right to access and correct information concerning ourselves, with the Informations Clients Service - AXA 313 Terrasses de l'Arche 92727 Nanterre Cedex, France. The contract takes effect, subject to the payment of the premium, on the date stated in the policy schedule. This is based on the date of receipt of the application form and the results of the medical questionnaires and any medical reports. The decision of the insurer applies to all members under the same policy.

Policyholder's / Employee's signature: _____

Date: _____