NOW HEALTH INTERNATIONAL

# WorldCare claim form

**Important information:**

Please complete the claim form in BLOCK CAPITALS and submit it to **Us** within six months of the initial **Treatment** date (unless this is not reasonably possible).

If the total amount **You** are claiming (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) is less than USD 500 **You** only need to complete Sections 1 and 2 and include a copy of **Your** receipt when **You** send **Us Your** claim form. **You** can scan **Your** claim form and receipt and email it to AsiaPacService@now-health.com or fax it to +852 2279 7330. Please keep a copy of the original documents in case they should be required by **Us**.

If the total amount **You** are claiming now or have claimed for (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) is over USD 500, please ensure Section 3 is completed by the treating **Medical Practitioner**. **We** must also see receipts, diagnostic reports and discharge reports (if **You** have been a **Day-Patient** or **In-Patient**) for claims over this amount. **You** can scan **Your** claim form and receipts/diagnostic reports/discharge reports and email them to AsiaPacService@now-health.com or fax them to +852 2279 7330. Please keep a copy of the original documents in case they should be required by **Us**.

**You** can track the progress of **Your** claim online at any time in **Your** online secure portfolio area. Log in at www.now-health.com using **Your** username and password.

If **You** have any questions about this form or any other aspect of your cover, please call us on +852 2279 7310 or email us at AsiaPacService@now-health.com.

## Section 1: Member and Patient Information:

| | |
|---|---|
| **Planholder's** name: | **Plan** number: |
| Patient's name: | Membership number: |
| Date of birth (dd/mm/yyyy): / / | |
| Claim settlement address: | |
| Email address: | Telephone number: |
| Reason for doctor visit/diagnosis: | |
| Country where **Treatment** took place: | **Treatment** date (dd/mm/yyyy): / / |
| Currency claim incurred in: | Currency **You** would like **Your** claim reimbursed in: |
| Total claimed amount: | Type of service: **Out-Patient** ☐ **Day-Patient** ☐ **In-Patient** ☐ |
| Attending physician: Dentist ☐ **Medical Practitioner** ☐ **Specialist** ☐ Other ☐ Please specify: | |
| Is this claim due to **Accident**/injury? Yes ☐ No ☐ If yes, include complete medical information. Date of **Accident**/injury (dd/mm/yyyy): / / | |

**Third party insurers**

If some of the costs are recoverable from a third party (for example, a person or organisation involved in an **Accident**), please provide details:

## Section 2: Payment details – please ensure all sections are completed

Please pay: **Planholder** ☐ Provider ☐

Please choose payment type: Bank transfer ☐ Foreign draft ☐ Cheque ☐

1. Bank transfer – please complete all details to enable bank transfer payments.*

| | |
|---|---|
| Account/payee name: | Payment currency: |
| Bank name: | Bank address: |
| Email address: | |
| IBAN or account no.: | Routing code (e.g. Swift or sort code): |

| | | |
|---|---|---|
| 2. Foreign draft – please specify currency: | Payee name: | Banking country: |

3. Cheque: Payee name

Claim settlement address:

* Please check with **Your** local bank as there may be a charge for this service.

**I have read the declaration in Section 4 on the next page**

I agree to the declaration and understand that any claim for **Benefit** is in accordance with the terms and conditions of **Our Plan**.

**Patient's signature (Insured/main applicant):** **Date** (dd/mm/yyyy): / /

## Section 3: Medical information, claims over USD 500

(to be completed by the doctor responsible for the patient's **Treatment**)

| | |
|---|---|
| **Medical Condition**: | Diagnosis ICD10 code: |
| Details of any underlying cause: | |
| | |
| When did the patient first see a doctor? (dd/mm/yyyy) / / | |
| Details of **Treatment**/medication: | |
| | |
| Details of operation (if any): | |
| | Procedure code: |
| **Hospital** details (if applicable): | **Treatment** date (dd/mm/yyyy): / / |
| Name: | |
| Address: | |
| | |
| Admission date (dd/mm/yyyy): / / | Discharge date (dd/mm/yyyy): / / |

**Medical Practitioner Declaration:**

I declare that I am the patient's **Medical Practitioner**, and that the particulars given are, to the best of my knowledge, true and correct.

| | |
|---|---|
| Print name: | Official stamp: |
| Signature: | |
| Date (dd/mm/yyyy): / / | |

If **Your Plan** includes a cash **Benefit**: If the patient stayed in **Hospital** overnight without charge please include confirmation from the **Hospital** including the **Hospital** stamp.
**Direct Billing:** It may be possible for **Us** to arrange direct settlement with the **Hospital** involved. Please call **Our** Customer Service team before **Treatment** to arrange this on +852 2279 7310.

## Section 4: Declaration and authorisation

**Data Protection**

**We** and the **Underwriters** will collect certain information about **You** in the course of considering **Your** claim. This information will be processed for the purposes of administering claims**. Your** information may be passed to **Underwriters**, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside the HKSAR. The same duty of confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those located outside the HKSAR. **Your** name and contact details will not be disclosed to other organisations (except as stated above).

**We** may contact **You** with details of other products and services which may be of interest to **You. You** may be contacted by post, telephone or email if appropriate. If **You** do not wish this to happen please tick this box ☐.

**Personal Data (Privacy) Ordinance**

It may be necessary to obtain a medical report from **Your** usual Doctor/**Medical Practitioner** for this claim. If **We** need to do this, this Ordinance gives **You** specific rights and they are set out below. If **You** wish:

1. **You** can refuse to give **Your** consent – but if **You** do **We** may be unable to deal with **Your** claim.
2. **You** can ask to see the report before it is sent to us. If **You** give **Your** consent, **We** will be able to contact **Your** Doctor direct for a report.
   If **You** wish to see it, delete the word "NOT" in the declaration and we will inform the Doctor accordingly. Then the doctor will not send it to **Us** until:
   i) **You** have seen the report and approved it; or
   ii) 21 days have passed since **We** requested the report and the Doctor has not heard from **You** .
   **Important note: The sooner We receive the report, the sooner We can deal with Your claim.**
3. Having seen the report, **You** can refuse **Your** consent – again this may affect **Our** ability to deal with **Your** claim.
4. **You** may ask the Doctor to change the report if **You** disagree with it. If (s)he refuses, **You** can require him/her to attach a statement of **Your** views to the report.
5. **You** may also ask the Doctor to let you see all reports supplied to **Us** within the last six months.
   **Important note: Your Doctor is entitled to charge You for supplying You with a copy of the report (to cover cost). This is not covered by Your Plan.**

**Your** Doctor may refuse to let **You** see **Your** report if (s)he feels it will do serious harm to **Your** physical or mental health, or it will indicate the Doctor's intentions in respect of **You**, or it may reveal the identity of another person who has supplied information about **You** who is not a health professional but is involved in **Your** care. In such cases **You** will be entitled to see the remainder of the report. If this affects the entire report, **Your** Doctor must obtain **Your** consent before (s)he sends it to **Us**.

**Important note: This relates to Hong Kong law and may differ in the country in which You reside.**

**Declaration**

I hereby declare that I am the patient/patient's guardian* (if the patient is under 16 years of age) (*please cross out if not applicable).

I wish to claim **Benefit** and declare the information I have given is, to the best of my knowledge, true, correct and complete even if it is not in my own handwriting.

I understand it is unlawful for me to knowingly provide false, incomplete or misleading facts or information to Now Health International for the purpose of defrauding or attempting to defraud Now Health International or the **Underwriters**. Penalties may include imprisonment, fines, denial of coverage, rescission of **Benefits** and legal damages.

I agree to the data protection declaration above and understand that cover is provided in accordance with the terms and conditions of the Now Health International **Plan**.

I have read the statement notifying me of my rights under the Personal Data (Privacy) Ordinance and consent to Now Health International seeking medical reports if needed from my **Medical Practitioner**, so Now Health International can deal with my claim for **Benefit**.

I do (NOT)* wish to see the medical report before it is sent to Now Health International. *Delete the word NOT if **You** wish to see the report.

I hereby consent to authorise any Doctor and/or **Hospital** who has treated or advised me to provide Now Health International with any information they may require in connection with this claim.

When completed and signed by the patient and **Medical Practitioner** (when appropriate), please return this form and the accompanying invoices and payment receipts to: Now Health International (Asia Pacific) Limited, Suite B, 33/F, 169 Electric Road, North Point, Hong Kong.

Plans issued in Hong Kong are underwritten by AXA General Insurance Hong Kong Limited and arranged by Now Health International (Asia Pacific) Limited.

Registered address: Suite B, 33/F, 169 Electric Road, North Point, Hong Kong. Insurance Agent Registration Number: 10974559.