MEDICAL EXPENSES / CURTAILMENT CLAIM FORM

Please submit your claim to
claims@optimumglobal.com

The insured member is required to complete the following claim form and attach all the original medical bills and supporting documentation when filing the claim.
Personal Data provided in this claim form or submitted as part of this claim will be used and processed by us in line with our Privacy Policy which can be found on our website, or which can be requested from us at any time.

SECTION A: PATIENT DETAILS TO BE COMPLETED BY INSURED MEMBER

Name of Main Applicant: ______ Membership No.: ______ Date of Birth: ______ Sex: ______

Name of Patient (If other than the main Applicant): ______ Membership No.: ______ Date of Birth: ______ Sex: ______

Present Contact Address: ______

Telephone number: ______ Email Address for Remittance Advice: ______

SECTION B: SETTLEMENT DETAILS

We settle all eligible claims by bank transfer (EFT), therefore it is important that you confirm your correct bank details every time you make a claim. Should the incorrect bank details be provided we reserve the right to charge an administrative fee to cover any charges incurred due to the error.

Total amount claimed (including currency): ______

Currency of Reimbursement: ______

Bank Transfer – **All fields in the box below are MANDATORY. If the account holder is not the claimant then you must state their relationship with the claimant and provide evidence of their permission for the funds to be transferred to their account (except in the case of a minor):**

Name of Account Holder (as it appears on bank statement): ______

Relationship to claimant ______

IBAN where applicable ______

Routing/intermediary information if required ______

Beneficiary Bank Account number (only if IBAN not applicable) ______

Account Holder address (residential address registered with the bank): ______

Name of Bank, Branch and Location: ______

Swift Code/BIC: ______ Sort Code (for UK banks only): ______

PLEASE NOTE:
- **Bank charges may apply when making bank transfers.**
- **Payments are not made directly to any clinic, physician or medical provider.**
- **If IBAN numbers are not used please ensure that the account number is entered and that the Swift Code/BIC is also completed.**

DECLARATION & AUTHORISATION

(This part must be signed by the patient or patient's parent/legal guardian if the patient is below 18 years of age)
I hereby authorise any hospital, physician, person or organisation to disclose all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I certify that the above statements and answers are true and complete to the best of my knowledge and belief.

Signature of Main Applicant ______ Date ______ Signature of Patient ______ Date ______

SECTION C: TRAVEL DETAILS

Travel Destination:

Country: ______________________________

Hotel: ______________________________

Departure Date: ______ / ______ / ______ Return Date: ______ / ______ / ______

Purpose of Trip: ☐ Business ☐ Pleasure

SECTION D: CLAIM DETAILS

Date, time and place of illness/injury: ____ / ____ / ____ ______ : ______ ☐ **AM** ☐ **PM**

Illness suffered or injuries sustained: ______________________________

____

If injury, please provide full circumstances of the incident: ______________________________

____

____

Have you suffered from a similar condition before? ☐ Yes ☐ No
If yes, please ask your doctor to complete the Medical Certificate attached.

Did you contact the Emergency Medical Assistance Company? ☐ Yes ☐ No

If yes, please provide the reference number given to you: ______________________________

Were you hospitalised as an in-patient? If so, please provide:

Date admitted: ____ / ____ / ____ Date discharged: ____ / ____ / ____

Time admitted: ____ : ____ ☐ **AM** ☐ **PM** Time discharged: ____ : ____ ☐ **AM** ☐ **PM**

If applicable, period of extended accommodation: ____ / ____ / ____ to ____ / ____ / ____

Did you return home early? ☐ Yes ☐ No

If yes, please provide the date on which you returned: ____ / ____ / ____

Do you hold any other insurance that may cover this loss? ☐ Yes ☐ No
(i.e. Private Health, Bank Account, Credit Card, Tour Operator)

If yes, please give details: ______________________________

SECTION E: DETAILS OF EXPENSES BEING CLAIMED

Date of Expense	Details of Expense	Amount Claimed	Receipt attached?	Paid / Unpaid?

OPTIMUM GLOBAL
INTERNATIONAL INSURANCE SOLUTIONS

SECTION F: GUIDANCE NOTES

The following documentation must be provided in order for your claim to be processed.

ITEM	ENCLOSED
Your original booking invoice which is sent to you at the time of booking your trip	☐
Evidence to support your claim Original receipts/invoices for expenses being claimed Hospital/Doctor reports/records	☐
If you returned home early: Confirmation from the treating Doctor of the medical necessity to return early, or if the return was as a result of an illness/death of a relative we require the medical certificate attached to be completed by the usual Doctor of the person causing curtailment.	☐
For Medical Expenses incurred in the EU only, please complete the attached disclaimer	☐
If the expenses are a result of an incident: Copies of any Police reports Details of the Third Party's insurance company Details of any solicitor that you may have appointed to handle a Personal Injury Claim	☐
If you have submitted a claim to another insurance company or third party: Copies of all correspondence	☐