HEALTH INSURANCE CLAIM FORM

Elmo INSURANCE

IMPORTANT NOTES

Please return this form with original invoices, receipts and a copy of test results to:
Elmo Insurance Ltd, Abate Rigord Street, Ta' Xbiex XBX 1111, Malta.

Please ensure that block capitals are used and that all sections of the claim form are fully completed to minimise any delays in handling your claim.

Claims are to be submitted within three months of the initial treatment date.

Specialist consultations must be on the initial recommendation of your General Practitioner. A new claim form must be completed for each patient and for each medical condition.

Pre-authorising treatment
You must always contact Elmo Insurance Ltd. before receiving any in-patient / day-patient treatment or a CT / MRI scan to enable us to confirm eligibility.

If you have any questions when completing this form please call us on **2343 0000** or e-mail us on health@elmoinsurance.com

1. POLICYHOLDER'S DETAILS – TO BE COMPLETED BY THE POLICYHOLDER

Policy number

Company name *(if applicable)*

Name and Surname

ID Number

Address

Telephone Number

Mobile Number

Email Address

2. PATIENT'S DETAILS – TO BE COMPLETED BY THE PATIENT UNDERGOING TREATMENT

Name and Surname

ID Number

Date of birth

Mobile number

Reason for seeking medical advice

Date patient first became aware of symptoms/condition?

Is this the first claim for these symptoms/condition? Yes ◯ No ◯

Is this claim the result of any accident? Yes ◯ No ◯

Are any of the costs recoverable from a third party, such as another insurance policy? Yes ◯ No ◯

If 'yes' please give details

3. GENERAL PRACTITIONER – TO BE COMPLETED BY THE GENERAL PRACTITIONER

Patient's name and surname

How long have you been the General Practitioner of this patient ?

Details of condition, symptoms and diagnosis

Date patient first became aware of symptoms/condition / /

Date of first consultation for these symptoms/condition / /

Drugs/treatment prescribed

What other treatment/medication is patient currently taking?

General Practitioner's signature and stamp

Details of specialist to whom patient has been referred

Telephone number

Date / /

4. CONSULTANT SPECIALIST – TO BE COMPLETED BY THE SPECIALIST REFERRED BY THE GP ABOVE

Patient's name and surname

Details of condition, symptoms and diagnosis

Date patient first became aware of symptoms/condition / /

Date of first consultation for these symptoms/condition / /

Specialist's signature and stamp

Drugs/treatment prescribed

Telephone number

Date / /

5. DATA PROTECTION NOTICE

Elmo Insurance Limited is committed to protect the security of your personal data and to ensure that your rights according to Data Protection Legislation are safeguarded. You may access our Data Protection Notice through the following link: www.elmoinsurance.com/online-security

6. DECLARATION

I have read and understood the Data Protection Notice and I declare that I am authorised to disclose personal data as required in this form relating to any included dependants.

I declare that to the best of my knowledge and belief, the statements and information provided by me in this form are true, accurate and complete and that I have not withheld any material information from Elmo Insurance Limited. I understand that if any information provided by me is incorrect or incomplete or if I fail to disclose any material information, Elmo Insurance Limited may cancel this policy and/ or repudiate any claims which may be made under this policy and I may encounter difficulty in obtaining insurance cover elsewhere.

I understand that Elmo Insurance Limited needs to process personal data concerning me or any included dependants, including personal data concerning health, in order to process, handle and/or settle this claim and I declare that I have no objection to such processing of personal data by Elmo Insurance Limited. I consent to the provision of any or all medical records relating to me or any included dependants to Elmo Insurance Limited as may be required for the purpose of the processing, handling or settlement of this claim. Consequently, I authorise any institution or person (including but not limited to doctors, nurses, surgeons, therapists, hospitals, clinics, laboratories and any other healthcare professional) who has been involved in my treatment or in the treatment of any included dependants, both in the past and present, to provide Elmo Insurance Limited with any information, including full medical records, reports or notes concerning my health or the health of any included dependants, in order for the validity of this claim to be established. Furthermore I authorise Elmo Insurance Limited to obtain from and/or share with other insurers and insurance intermediaries personal data concerning my health or the health of any included dependants in order to prevent, detect and/or suppress insurance fraud.

Policy Holder's signature

Date / /

Dependant's signature (over 18 years of age)

Date / /