

This form is made up of five short sections:

- A** Policyholder's and patient's details
- B** Details of any secondary insurance
- C** Medical details
- D** Payment options
- E** Declaration

Please complete form in full. Failure to do so may delay the payment of your claim. Proof of claim must be submitted within 180 days of accident or illness. A separate claim form should be used for each patient and each medical condition.

All claims should be completed in English. If submitting invoices in other languages, please provide a brief description.

FORM CHECKLIST

✓ Only complete this form if you are claiming on your health insurance policy. If you require a different form please call **+44 333 405 3003**

✓ Please check you have signed and dated the form on the last page.

Once completed please email your form with itemised bills and receipts to:

integra@medical-administrators.com

Alternatively, post it to: **INTEGRA – MAI Claims Department, 39 rue Anatole France, 92300 Levallois-Perret – France**

SECTION A POLICYHOLDER'S AND PATIENT'S DETAILS

Membership number Find this on your membership certificate or on your ID card.	<input type="text"/>		
Policyholder's name	<input type="text"/>		
Policyholder's date of birth (DD/MM/YYYY)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Policyholder's email address	<input type="text"/>		
Patient's relationship to the policyholder	<input type="checkbox"/> I am the policyholder (Please go to section B)	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
Patient's name	<input type="text"/>		
Patient's date of birth (DD/MM/YYYY)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient's gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Patient's email address	<input type="text"/>		

SECTION B DETAILS OF ANY SECONDARY INSURANCE

Policy number	<input type="text"/>
Policyholder's name	<input type="text"/>
Patient's name	<input type="text"/>
Insurance company	<input type="text"/>

SECTION C MEDICAL DETAILS

All sections must be completed by either the provider or member.
 For foreign language claims, please complete this section in English.

MEDICAL PRACTITIONER'S DETAILS

Name

Address

PATIENT'S DIAGNOSIS AND TREATMENT

Diagnosis/symptoms

Onset date when symptoms first noticed by patient (DD/MM/YYYY)

CLAIM 1

When did the patient first see a doctor? (DD/MM/YYYY)

Details of treatment and costs	Details	Costs and currency
	<input type="text"/>	<input type="text"/>

Details of operation and costs	Details	Costs and currency
	<input type="text"/>	<input type="text"/>

Details of medication and costs	Details	Costs and currency
	<input type="text"/>	<input type="text"/>

CLAIM 2

When did the patient first see a doctor? (DD/MM/YYYY)

Details of treatment and costs	Details	Costs and currency
	<input type="text"/>	<input type="text"/>

Details of operation and costs	Details	Costs and currency
	<input type="text"/>	<input type="text"/>

Details of medication and costs	Details	Costs and currency
	<input type="text"/>	<input type="text"/>

SECTION C MEDICAL DETAILS

CLAIM 3

When did the patient first see a doctor? (DD/MM/YYYY)

--	--	--

Details of treatment and costs

Details

--

Costs and currency

--

Details of operation and costs

Details

--

Costs and currency

--

Details of medication and costs

Details

--

Costs and currency

--

HOSPITAL DETAILS (for inpatient claims only)

Hospital admission date (DD/MM/YYYY)

--	--	--

Discharge date (DD/MM/YYYY)

--	--	--

Hospital name and address

--

Telephone

--

Email

--

CHARGES

Charges and currency

--

SECTION E DECLARATION

Data protection and release of medical records

References to information includes personal information given by you to us, in your claim or pre-authorisation form and/or supporting documents/information we collect in connection with products or services we provide.

Personal information may be used for insurance administration (e.g. underwriting, claims handling, fraud prevention). We may use third parties to process data on our behalf. Such processing is subject to contractual restrictions regarding confidentiality and security in line with data protection obligations.

We need to collect sensitive data relating to you (e.g. health details), to assess insurance terms and/or administer claims.

We may share your information with our agents, other insurers and their agents, service providers, any intermediary acting on your behalf or governing/regulatory bodies (of which we are a member or by which we are governed). In certain circumstances, we may use private investigators to investigate a claim you have submitted.

We are obliged to retain your records for six years from the date the insurance relationship ends. We will not retain your data for longer than necessary and will hold it only for the purposes for which it was obtained.

By signing this form you confirm that you have the authority to act on behalf of your dependents in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependents.

You have the right to request and receive a copy of your personal data held by us. If you wish to do this, please write to us at the address provided on this form or via: **member-care@integraglobal.com**

Where personal information is collected about individuals in connection with the arranging of insurance, this information will be collected and processed in accordance with our Privacy Policy which can be viewed on our website: **www.integraglobal.com/privacy-policy**. Alternatively, you can contact us for a copy.

Calls to our helpline may be recorded and monitored for training, quality and regulatory purposes.

I certify that to the best of my knowledge, this claim form does not contain any false, misleading or incomplete information. I understand that in the event that this claim is found to be fraudulent, in whole or in part, the contract will be cancelled from the date of discovery of the fraudulent event and I may be liable to prosecution.

I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I authorise my medical practitioner, health professional or other relevant medical establishment to provide relevant medical information relating to me, if requested by us, our medical advisers, appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply.

If a minor was treated, a parent or guardian should sign this section.

PRIMARY INSURED SIGNATURE

DATE (DD/MM/YYYY)