CLAIM FORM

This form enables the insurer (ARGO Syndicate 5319 at Lloyd's) or HealthWatch SA on the insurer's behalf to: assess a claim, request a medical report or discuss the patient's treatment with their physician or hospital if we need further information about the claim.

With the exception of section 3, each section of this form requires completion. If a section requires completion, the section's heading or the section itself makes clear who must complete it. For example, section 6 must be completed by the patient's physician or hospital.

Please complete the form in block capitals and check the responses you provide.

Patient's details (To be completed by the patient unless under 16 years of age)

Policy Number:

Patient's name:

Email Address:

Last name:

Patient's telephone number:

Patient's date of birth: D D M M Y Y

1. Patient's details (To be completed by the person who paid the medical bills)

Our usual practice is to settle eligible bills directly with the physician or hospital concerned. If you have already paid the invoices yourself please send us the receipts and we will reimburse you if, and to the extent that, there is cover, by cheque or wire transfer direct to your bank account. For reimbursements please complete this section with your bank account details. We cannot reimburse to credit or debit cards, so please do not list any card numbers on this form.

1.1 Currency for claim to be paid in:

1.2 Bank account number:

1.3 Payee name:

1.4 Bank name and postal address:

1.5 Country:

1.6 IBAN*:

1.7 Swift code*:

1.8 Account name:

1.9 ABA number:

*Note: the IBAN and Swift codes are required if payment is to be made in Euros

2. Additional information (To be completed by the patient unless under 16 years of age)

2.1 **Hospital details**
Are you claiming cash benefit for in-patient treatment received without charge? ◯ Yes ◯ No

If Yes, please state the admission and discharge dates and enclose a certificate from the hospital confirming the dates of the stay.

Admission date: D D M M Y Y

Discharge date: D D M M Y Y

2.5 Has the policy Excess been paid? ◯ Yes ◯ No

If Yes, please state to whom

2.6 Has the European Health Card been used? ◯ Yes ◯ No

2.2 **Third party involvement**
Is the treatment because of an injury caused by an accident? Yes ◯ No ◯

2.2.1 If Yes, who was responsible for causing the accident?

2.3 **If yes,** did it involve a third party you may be making a claim against? Yes ◯ No ◯

2.3.1 If Yes, please provide full contact details.

2.4 Do you have any other insurance policy that could also cover your costs, for example a travel cover policy? Yes ◯ No ◯

2.4.1 If yes, please provide full details including Insurer, contact address and Policy Number

3. Your personal information notice

Who we are
The insurer identified in the Certificate of Insurance and the Policy Wording – namely, ARGO Syndicate 5319 at Lloyd's.

The basics
The insurer collects and uses relevant information about you to provide you with your insurance cover or the insurance cover that benefits you and to meet its legal obligations.

This information includes details such as your name, address and contact details and any other information that the insurer collects about you in connection with the insurance cover from which you benefit. The information includes more sensitive details: information about your health.

In certain circumstances, the insurer may need your consent to process information about your health. Where it needs your consent, you will be asked for this separately. You do not have to give your consent and you may withdraw your consent at any time. However, if you do not give your consent, or you withdraw your consent, this may affect the insurer's ability to provide the insurance cover from which you benefit and may prevent the insurer from providing cover for you or handling your claims.

The way insurance works means that your information may be shared with, and used by, a number of third parties in the insurance sector for example, insurers, agents or brokers, reinsurers, loss adjusters, sub-contractors, regulators, law enforcement agencies, fraud and crime prevention and detection agencies and compulsory insurance databases. The insurer will only disclose your personal information in connection with the insurance cover that it provides and to the extent required or permitted by law.

Other people's details you provide to the insurer
Where you provide the insurer or your agent or broker with details about other people, you must provide this notice to them.

Want more details?
For more information about how the insurer uses your personal information please see its full privacy notice which is available online on its website www.argolimited.com/gdpr-policy/ or in other formats on request.

Contacting us and your rights
You have rights in relation to the information the insurer holds about you, including the right to access your information. If you wish to exercise your rights, discuss how the insurer uses your information or request a copy of its full privacy notice, please write to:

The Compliance Department:
ARGO Syndicate 5319 at Lloyd's
1 Fen Court, London
EC3M 5BN
TEL: 020 7712 7600

Please provide your broker's company name when writing to the insurer

4. Personal information and access to medical information consent wordings

a) Your personal information and access to your medical information

This section applies if you are the patient i.e. the person to whom this claim relates and are aged 16 or over at the time of completion of this Claim Form

The insurer - namely, ARGO Syndicate 5319 at Lloyd's - and other insurance market participants need your consent to use the sensitive details about you included in this Claim Form and to request medical information, if needed, from your physician in connection with your claim.

"Other insurance market participants" include the insurer's third party agent named below:
- HealthWatch SA (for the purposes of claims assessment, decision making and administration).

You do not have to give your consent and you may withdraw your consent at any time. However, if you do not give your consent, or you withdraw your consent, this may prevent the insurer from handling or otherwise affect its ability to handle your claim.

If the insurer needs medical information from your physician in connection with your claim, you have a right to see this information before it is provided to the insurer. If the insurer needs the medical information – and you have given your consent to it being requested – you will be advised in writing of the date it was requested.

If you exercise your right to see the medical information, the insurer will request that your physician keeps it for 21 days from the date it's requested so that you can arrange to see it. If you have not made arrangements to see the medical information within this time, your physician will be entitled to send it to the insurer.

If you choose not to see the medical information from your physician at this stage, you may ask them for a copy or the insurer for a copy (which the insurer will send to your physician).

If, having chosen to see the medical information, you think that any of it is not correct or is misleading, you may ask your physician to amend it. If your physician refuses to do this, you may ask them to attach a statement outlining your views, which will then accompany the medical information.

Your physician may charge you for their provision of your medical information. Please note that, if they do, the cost is not recoverable under your DCare International Medical Insurance policy.

Your physician can withhold access to your medical information if, and to the extent that, they are of the opinion that it would cause physical or mental harm to you or others.

In connection with your claim, do you consent to: Yes ◯ No ◯

- the use of data and information about your health;
- the insurer requesting your medical information, if needed, from your physician; and
- your physician providing your medical information, if needed, to the insurer?

If the insurer needs to request your medical information from your physician in connection with your claim, do you want see this before it is sent to the insurer?

Yes ◯ No ◯

b) Another person's personal information and access to their medical information

This section applies if you are not the patient i.e. you are not the person to whom this claim relates but the patient is below the age of 16 years at the time of completion of this Claim Form and you are a holder of parental responsibility over them

Where you provide the insurer with details about another person, it and other insurance market participants need their consent to use the sensitive details about them included in this Claim Form and to request medical information if needed, from their physician in connection with their claim.

"Other insurance market participants" include the insurer's third party agent named below:

- HealthWatch SA (for the purposes of claims assessment, decision making and administration).

However, where the other person is a child below the age of 16 years at the time of completion of this Claim Form, the consent must be given by a holder of parental responsibility over the child.

Consent does not have to be given and may be withdrawn at any time. However, if consent is not given, or if it is withdrawn, this may prevent the insurer from handling or otherwise affect its ability to handle the other person's claim.

If the insurer needs medical information from the other person's physician in connection with their claim, they have a right to see this information before it is provided to the insurer.

If the insurer needs the medical information - and consent has been given to it being requested – the other person will be advised in writing of the date it was requested. However, if the other person is a child below the age of 16 years at the time of completion of this Claim Form, this advice will instead be provided to the relevant holder of parental responsibility over the child.

If the right to see the other person's medical information is exercised, the insurer will request that their physician keeps it for 21 days from the date it's requested so this can be arranged. If arrangements have not been made to see the medical information within this time, the physician will be entitled to send it to the insurer.

If the right to see the other person's medical information from their physician is not exercised at this stage, a copy may be requested from the physician or from the insurer. If a copy is requested from the insurer, they will send this to the physician.

If, having exercised the right to see the other person's medical information, any of it is thought to be not correct or misleading, their physician may be asked to amend it. If the physician refuses to do this, they may be asked to attach a statement outlining the (contrary) views, which will then accompany the medical information.

The other person's physician may charge for their provision of the medical information. Please note that, if they do, the cost is not recoverable under the DCare International Medical Insurance policy.

The other person's physician can withhold access to the medical information if, and to the extent that, they are of the opinion that it would cause physical or mental harm to that person or to others.

For each other person (who is a child below the age of 16 years at the time of completion of this Claim Form) whose information you provide to the insurer in connection with that person's claim, are you a holder of parental responsibility over them?

Yes ◯ No ◯

For each such person in connection with their claim, do you give your consent in the capacity of being a holder of parental responsibility over them, to:

- the use of data and information about their health;
- the insurer requesting their medical information, if needed, from their physician; and
- their physician providing their medical information, if needed, to the insurer?

Yes ◯ No ◯

If the insurer needs to request medical information from such other person's or persons' physician/s in connection with their claim, do you want to see this before it is sent to the insurer?

Yes ◯ No ◯

5. Declaration

I declare that I am the patient (meaning a or the person to whom this claim relates).

Yes ◯ No ◯

I declare that I am not the patient but that the patient is a child below the age of 16 years at the time of completion of this Claim Form and I am a holder of parental responsibility over them.

Yes ◯ No ◯

I declare that the information I have supplied in this Claim Form is true and fully accurate to the best of my knowledge.

Yes ◯ No ◯

I understand that, if I do not take reasonable care to answer all of the questions in this Claim Form accurately, or if the policy terms and conditions are not complied with, this may result in a claim being delayed, only partially paid or not paid at all.

Yes ◯ No ◯

Signed

Full name

Dated

Patient's details

Policy Number:

Patient's name:

Patient's date of birth:

D D M M Y Y

6. Medical details (To be completed by the patient's physician or hospital)

6.1 The illness or injury requiring consultation/treatment

6.2 If claim is related to a pregnancy:

Date of your last monthly period

The date on which the pregnancy was confirmed

Delivery Date

6.3 How long did your patient have any symptoms/consultation/ of the illness or injury prior to first visiting any physician?

6.4 What is the date your patient first visited any physician about the illness or injury?

D D M M Y Y

6.5 Please give a full history of the illness or injury requiring consultation/treatment, including details of any previous and current symptoms/consultation/investigation/treatment/medication together with all relevant dates.

6.6 Please advise if the patient has previously sought treatment or advice with any physician, or received any medication, for the illness or injury or followed any special diet. Please include full details including dates.

◯ Yes ◯ No If yes, please give details below

6.7 Please give any other medical history relevant to the illness or injury being claimed for.

6.8 Future treatment plan, including proposed frequency and overall length of treatment and expected dates of treatment sessions.

6.9 Circumstances of illness or injury

I am the patient's physician and confirm the information I have provided, is to the best of my knowledge.
I understand that the accuracy of the information provided may affect my patient's insurance claim.

Physician's signature:

Print Name:

Telephone:

Fax:

Email:

Date: D D M M Y Y

Physician's or hospital's stamp:

Once this Claim Form has been completed, please send it, together with all supporting information and bills, to HealthWatch SA by:

- Email: dcare@healthwatch.gr
- Fax : +302 310808099
- Post : HealthWatch SA
  Amigdalies 5
  P.O. 564 29 N.EFKARPIA
  THESSALONIKIS
  GREECE

PLEASE RETAIN A COPY OF ALL THE DOCUMENTATION YOU SEND FOR YOUR RECORDS.