

# InterGlobal HealthCare Plans

## Claim Form for Medical Treatment Reimbursements



Please complete clearly in block capitals. Information about how to complete can be found on the reverse of this form.  
Please call us Toll Free: 0120-76-7703 or email [japan-claims@interglobal.co.jp](mailto:japan-claims@interglobal.co.jp) if you require any further assistance.

Send your claim to: Claims Team, InterGlobal Japan Limited, 3F Koike Koraibashi Bldg., 1-3-4 Koraibashi, Chuo-Ku, Osaka, 541-0043, Japan.  
W [www.interglobalpmi.com](http://www.interglobalpmi.com)

### About your claim

Your claim will be processed by InterGlobal Limited on behalf of the insurer. Please enclose the original invoices – photocopies, receipts and credit card vouchers are not acceptable. We are unable to return original documents, but we will be happy to provide certified copies on request.

### A Patient details

If the patient is a dependant under the age of 18, the main member must complete sections A to H for the patient.

Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/>	Other:
Family name:	First name(s):
Date of birth (dd/mm/yy):	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Group name (if applicable):	
Member number:	Plan number:
Correspondence address:	
Town:	Postal code:
Country:	Email:
Daytime telephone:	Fax:
Evening telephone:	

Symptoms/condition needing treatment:

### B Main member details (if different from section A Patient details, above)

Family name:	First name(s):
Member number:	Plan number:

### C Further information

Does the patient have another insurance policy that covers medical costs?  Yes  No If yes, please provide details on a separate sheet.  
If you have suffered an injury as the result of an accident, are you claiming from a third party?  Yes  No If yes, please provide details on a separate sheet.

Is your claim as a result of an accident?  Yes  No If yes, please provide the circumstances of the accident and how it happened on a separate sheet.

### D Hospital cash benefit

Are you claiming hospital cash benefit?  Yes  No

If yes:

- Please send us the original admission and discharge form from the hospital where the treatment was provided

### E Medical Information

#### 1. Contact details

Please provide details of the medical practitioner/specialist/consultant/therapist who treated you:

Name:	
Telephone:	Fax:
Address:	

#### 2. Symptoms

Please provide full details of the symptoms needing treatment:

On what date did you first notice these symptoms? (dd/mm/yy):
On what date did you first present these symptoms to your medical practitioner? (dd/mm/yy):
Have you suffered from the same or similar symptoms before? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide complete current and previous history including dates:
Are your symptoms a result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No

**E Medical Information (continued)**

If yes, please provide full details below (please note we may contact you for further information if required):


**3. Investigations requested**

If you underwent diagnostic procedures or tests, e.g. CT scans or blood tests please detail which procedures were performed and their results:


Please detail all medications prescribed (if you were provided with a sheet detailing the medication from your pharmacist, please attach a copy to this claim form):


**4. Diagnosis**

Diagnosis of medical condition, if known:

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**5. Treatment**

What was the treatment proposed by your medical practitioner/specialist/consultant/therapist who treated you:

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Do you need a follow-up visit?  Yes  No

If yes, when? (dd/mm/yy):

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**6. Maternity treatment**

When was your last menstrual period? (dd/mm/yy):

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Is the pregnancy a result of infertility treatment/medication, including conception by artificial means?  Yes  No

If yes, please provide the method of conception:

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**F Claim details**

Date of treatment	Invoice date	Invoice reference	Amount (including currency)

**G Payment details**

Have you personally had to pay costs for the treatment that you are claiming for?  Yes  No

If yes, and you are personally seeking reimbursement, please tell us how you wish to be reimbursed (please tick one option below). Please note that we will only issue payment to the claimant if they are 18 or over, another dependant on your plan if they are 18 or over, the main member on the plan, or the planholder.

1. Bank transfer – please complete this information for bank transfer payments (note that this is the quickest and safest method of payment).

Name of account holder:

Account number:

Currency of bank account:

Please ensure that you complete the mandatory information required below – failure to do so may result in delays in you receiving the claim settlement and you incurring additional bank charges.

a) IBAN number (mandatory for all payments within the EEA (European Economic Area), Kuwait and UAE (United Arab Emirates)):

Name of your bank:

Address of your bank:

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**G Payment details (continued)**

Or

b) BIC/SWIFT code (mandatory for all other transfers):
Name of your bank:
Address of your bank:

Also, to help us direct your payments efficiently please supply as relevant:

Sort code (mandatory for UK banks): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 6 digit number	Routing code/branch code:
ABA number (mandatory for transfers to US located banks): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 9 digit number	
RUT (mandatory for CLP (Chilean Peso) transfers):	
<input type="checkbox"/> 2. Foreign draft. Please specify currency:	
Name to appear on the draft:	Currency of the draft:
<input type="checkbox"/> 3. Credit card. Please complete this information for credit card payments. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Currency of credit card:	Expiry date (mm/yy)
Name (as it appears on card):	Card type:

**H Data protection notice, your consent and declaration**

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with the UK Data Protection Act 1998, medical confidentiality guidelines, other related legislation and our own strict internal policy.

We will use any personal data we collect about you and where appropriate, your dependants, to process your claims, administer your policy, detect and prevent fraud, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

We may also, in carrying out your instructions, processing and administering claims, transfer your personal data to other InterGlobal entities and/or third parties acting on our behalf inside or outside the European Union where there may be less stringent data protection laws. However, wherever it is held and processed, your personal data will be protected by a strict code of secrecy and security which we and any third parties working on our behalf are subject to and will only be used in accordance with our instructions.

Your information may also be used for fraud prevention or improper claims and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to other InterGlobal entities or agents or others as permitted by law so that they may do the same, and they may pass information held by them about you to us so that we may do the same.

We will not disclose any such information outside of the Company except for fraud prevention purposes, and/or if required/obliged by law or governmental or judicial bodies or agencies or to our regulators under proper authority.

Your medical information will only be disclosed to those involved with your treatment or care, including your general practitioner/primary health physician, or to their agents. If you ask us to, we will also send your medical information to any person or organisation who may be responsible for meeting your treatment expenses, or their agents.

We will communicate directly with you about your claim if you are aged 18 or over, or with the main member if you are under 18 unless we are advised otherwise. Claims information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information, or to another person that you have authorised us to provide such information.

If you want us to disclose your medical information to another individual or next of kin, please complete the section below.

I would like information about this claim to be provided to:

Name:	Relationship:
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**Access to Medical Records Act 1988**

In order to process your claim, we may need to apply for a medical report from any medical practitioner that has attended you. We will require your consent before we can apply for this.

Under the law, you can:

1. Give your consent. If you choose this option, your medical practitioner will send the report direct to us.
2. Request to see the medical report before it is sent to us. If you choose this option, we will notify the medical practitioner of your request when we apply for your records. You must contact your medical practitioner within 21 days of our notifying you that we have requested a medical report about you to make arrangements to see the report. If you fail to make contact within 21 days, the medical practitioner will be entitled to send the medical report direct to us. You also have a right to request the correction of any information you believe is misleading or incorrect. After you have seen the report, you must give your consent before the medical practitioner can release the report to us.
3. You have a right to withhold your consent. Please note that if you choose this option, we may be unable to accept or process your claim.

You have a right to ask your medical practitioner for any report (whether or not you had previously requested to see it) we have requested within six months of its having been supplied to us. Your medical practitioner is entitled to withhold some or all of the information contained in the report if (a) he feels that it may be harmful to you or (b) it would indicate his intentions in respect of you or (c) would reveal the identity of another person without their consent (other than that provided by a health professional in their professional capacity in relation to your care). Your medical practitioner may also charge you for any of these services.

**Signed declaration**

I declare that all the details given on this claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I am committing a criminal offence and that this will invalidate the plan and make me liable to prosecution. For this medical claim I authorise any medical practitioner, specialist, consultant, therapist or other relevant establishment who has attended me/the patient in the past or is attending me/the patient at present, to give any details that may be asked for by the insurer or authorised administrator. I confirm and agree that any personal information collected or held by the insurer or authorised administrator, whether given in this form or collected in any other way, may be used by the insurer or authorised administrator, or disclosed to or transferred to any organisation for the purpose of i) assessing this claim and giving ongoing insurance cover, customer service and the processing of future claims, ii) processing and making payments, and iii) within the limits of relevant consents, providing marketing communications in respect of the insurer, its related products and services and those of its associated companies. I understand that InterGlobal Insurance Company Limited may use organisations who may be located in the EEA or elsewhere. Where an organisation is located outside the EEA, InterGlobal Insurance Company Limited will take all necessary steps to ensure the organisation provides appropriate guarantees in respect of their technical and organisational security measures and the transfer and processing complies with all relevant data protection and privacy laws.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, (on behalf of myself and any family members specified in this form) for InterGlobal Insurance Company Limited to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members.

Our full terms and conditions and details of our privacy policy can be found at [www.interglobalpmi.com](http://www.interglobalpmi.com)

Patient's/member's signature:	Date (dd/mm/yy):
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**For office use only**

Policy number:	Member number:	Claim number:
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## Important information

Please make sure that all invoices show all of the following details:

- Claimant's name
- Date of service
- Diagnosis
- Itemised charges

Please remember these important points when completing your claim form:

- Assessment of your claim may be delayed if you do not complete all the necessary sections of this form
- Complete one form per medical condition, per person
- Return this form to us within six (6) months of first treatment date
- Always send us the original invoices with this form. Photocopies, receipts and credit card statements will not be accepted
- If you were provided with a sheet from your pharmacist detailing prescribed medication, please attach this to the claim form
- We will not refund non-medical costs such as medical reports unless explicitly requested by us. Depending on the condition/loss, we may require further medical, dental, or police reports
- Most mobile phone email addresses cannot receive attachments. Please provide a PC email address if possible

## Section A

If the patient is a dependant under the age of 18, the main member must complete the form and sign the declaration for them.

If the patient is under 18 and has their own plan, a parent or legal guardian must complete the form and sign the declaration for them.

## Section D

You can claim hospital cash benefit if you have stayed overnight in hospital and the hospital has not charged you or any other party for treatment. Please see your plan guide and table of benefits for more information on hospital cash benefits.

## Section E

Please ensure you answer all the questions on the medical section of the claim form as detailed as possible.

## Section G

If you are not personally seeking reimbursement we will pay the treatment provider direct, as long as the payment instructions are shown clearly on the invoice. If you are personally seeking reimbursement, you need to tell us how you wish to be reimbursed.

- Please ensure that you are able to receive payment in the method and currency you have requested. We reserve the right to pass on any payment charges incurred by us for cancelling payments based on information you have provided.
- We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details.
- If you do not give us the sort code/routing code, BIC (swift code) and IBAN number, you may incur bank charges and it will result in a delay in us paying your claim.
- Payment by foreign draft in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.
- We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative. If you do not specify a payment currency, we will pay your claim in the currency of your plan.

We cannot make payment in the following currencies, but if in doubt, please refer to us:

Brunei Dollars (BND), Chinese Yuan Renminbi (RMB), Lebanese Pounds (LBP), Russian Ruble (RUB), Venezuelan Bolivares (VEB), Zimbabwean Dollars (ZWD).

If you do not specify a payment currency, we will pay your claim in the currency of your plan.

- Please note we cannot make claim reimbursement payments via foreign draft or cheque to banks based in Qatar.
- Please note we are unable to make claim payment reimbursements via bank transfer to Japan Post Banks as they do not accept international remittances.
- Japanese banks will often charge for processing a foreign draft or cheque. Most Japanese Banks will not process foreign drafts or cheques in any currency other than Japanese Yen.
- We are able to settle the claims to the following credit cards and in most currencies:
  - Diners
  - MasterCard
  - Visa

In the event that we are unable to make payment in the currency you have specified, we will contact you to confirm an alternative.

## Section H

If the declaration has not been read and signed, we will not be able to process your claim.

## No claims discount

The NCD applies to individual and family plans and not group plans. Any claims made under the wellness benefit or under a benefit on an optional add-on plan will not affect the NCD.

Claims made under all other benefits will affect your NCD.

## Excess

If you have an excess on your plan, this will be deducted as per the excess on your plan from any reimbursement.

## Checklist

Have you sent to us:

- A fully completed claim form with signed and dated declaration?
- Original itemised invoices (copies will not be accepted)?
- Original hospital admission and discharge form if claiming hospital cash benefit?
- A copy of prescribed medication's description and instruction sheet.