International Solutions claim form

Please complete all relevant sections of this form, including 'Medical certificate' where appropriate and return to us. Please note that if you are charged for completing this claim form, Aviva will not refund this cost. The issue of this claim form is in no way an admission of liability.

We will correspond by secure email whenever possible. **Email** internationalhealth@aviva.co.uk
Send to: Aviva Health UK Limited, International Team 14, Chilworth House, Hampshire Corporate Park, Templar's Way, Eastleigh, SO53 3RY.
Telephone +44 (0) 2380 308925 **Fax** +44 (0) 1603 350414. Calls may be monitored and/or recorded.

Policyholder's name		Company name (if applicable)	
Policy number		Claim number (if known)	

Claimant's details

Name		Date of birth	D D / M M / Y Y Y Y
Street address			
Town/city			
County/state			
Postcode/zipcode			
Country			
Telephone (Home)		Telephone (Mobile)	
Email			

Other insurer involvement / third party claims

Do you have any other insurance, including any provided by the state, which covers your claim or provides a contribution to it? yes ☐ no ☐

If yes, please tell us how much will be / has been paid by the other insurance

Do you consider that another person or company may be responsible for your illness or injury? yes ☐ no ☐

If you have answered 'Yes' to either of these questions we may contact you for further details

Claims for optical benefits

To claim for prescription glasses, sunglasses or contact lenses you must have been given a new prescription or a change of prescription. Please enclose a copy of the prescription

Do you have a new prescription or a change of prescription? yes ☐ no ☐ Date D D / M M / Y Y Y Y

Are you claiming for a routine sight examination? yes ☐ no ☐ Date D D / M M / Y Y Y Y

Claims for the death of a close relative - please supply a copy of the death certificate and any airline / travel tickets or receipts / itinerary

Name of deceased person

Date of death D D / M M / Y Y Y Y

Date of travel (Outbound) D D / M M / Y Y Y Y

Date of travel (Return) D D / M M / Y Y Y Y

Relationship of claimant to deceased person

Country of funeral

Cost of the flight

Medical claims

This section is for medical claims. If you have full medical underwriting (FMU), please make sure the 'Medical certificate' at the end of this claim form is fully completed

Claim details

Please tell us the symptoms that you have been experiencing

How long have you been experiencing these symptoms? Please give dates

Have you experienced these symptoms before? If yes, please tell us when they first started yes ☐ no ☐

Please list any regular medication that you take.

Please detail the medical expenses you are claiming for. You need to attach original bills/invoices and receipts or, if appropriate, other original documents

If you are claiming for more than one medical condition you will either need to complete a separate claim form for each medical condition or call us

Medical service received (for example X-ray or removal of tissue for biopsy)	Name of service provider (for example the hospital or doctor)	Currency of the bill (for example US dollars)	Amount of the bill (please indicate if paid)	Date of treatment
				DD/MM/YYYY
				DD/MM/YYYY
				DD/MM/YYYY
				DD/MM/YYYY
				DD/MM/YYYY

Total

Which currency do you want us to pay the claim in?

Note: If you choose to have the claim paid in a different currency to the one your premiums are paid in, or you have paid the bill in a different currency, this may result in a delay in us paying your claim. If your chosen currency is not available, we will contact you

Bank details. If you do not complete this section in full, or tell us incorrect details, there may be a delay in payment

We can reimburse you directly by transferring the money to your bank account. Please refer to your bank if you have any queries regarding payment by international bank transfer. We can also reimburse you by draft or pounds sterling cheque but payment will take longer to reach you

Account name(s) / payee name (as they appear on your account)

How would you like us to reimburse you? bank transfer ☐ draft ☐ pounds sterling cheque ☐

Bank name and address

Sort code, Swift code or BIC number

Account number or IBAN number

Routing number (if a US bank), transit code (if a Canadian bank) or BSB code (if an Australian bank)

Consent to obtain a medical report

We may need further information from your doctor to enable us to make a decision on your claim. We can only obtain this with your consent and therefore need you to sign and date the 'Consent and declaration' section on the next page.

You should be aware that you have certain rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (these acts only apply to UK medical records). The main points of the Act are as follows:

a) If you tell us (in the declaration) that you do not wish to see the report we will not notify you if we apply for one. However, if before such a report is sent to us you write to your doctor requesting to see it, you will have 21 days to contact your doctor about arrangements for you to see the report.

b) If you indicate (in the declaration) that you wish to see the report, we will write to you at the same time as we contact your doctor. We will say that you have asked to see the report and that you have 21 days to contact your doctor to make arrangements to do so. When you have seen the report the doctor may not send it to us until you have given your consent to do so.

   If you do not contact your doctor within 21 days the report will be sent to us.

c) You can ask your doctor if he/she will amend any part of the report which you consider to be incorrect or misleading. If your doctor is not in agreement, you may attach your comments.

d) During the six months after we have received your report you may ask your doctor to see a copy. Should you ask for a personal copy of the report the doctor can charge you a reasonable fee to cover the cost.

e) In some circumstances the doctor may decide, in the interest of your health, or to respect the interest of others, that you should not see all or part of the report. The doctor will notify you of this and you will have the right to see any remaining part of the report. If it is the whole of the report which is affected, this will not be given to us without your consent.

f) You can withhold your consent. In this case we may be unable to proceed with your claim.

Consent and declaration

Please read the declaration and complete the boxes below:

I have read the section about my rights under the Access to Medical Reports Act 1988 (or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991). I agree to the provision of any and/or all of my medical records to Aviva in connection with this claim.

By signing below, I give my permission to any institution or person (including, but not limited to, hospitals, doctors, nurses and health professionals) who has been involved in my treatment both past and present, to provide Aviva (and third parties acting on its behalf) with any information, including full medical records, reports or notes, concerning my physical or mental health.

I consent to the:

- processing (by computer or otherwise);
- use (which may happen outside the European Economic Area) for the purpose of medical underwriting, claims assessment and validation, fraud prevention, policy administration, service provision and reinsurance; and
- disclosure to the policyholder, relevant intermediaries and medical service providers

of personal and medical details supplied in support of this claim. I agree that a copy of this consent shall have the validity of the original.

The data controllers are Aviva Health UK Limited, Aviva Life & Pensions UK Limited and Aviva Insurance Limited.

I DO NOT wish to see the report before it is sent to Aviva (*please delete if you wish to see the report before it is sent to us).*

If you do not consent to Aviva obtaining a medical report, please tick this box ☐

I declare that, to the best of my knowledge and belief, the information given on this form is true and complete.

Signature of patient (or signature of parent or guardian, if patient is under 16 years old).

Signature

Print name

Date D D / M M / Y Y Y Y

Data Protection Act - consent to discuss claims with another person

Due to data protection rules we are unable to discuss your claim with other people. This may sometimes cause you inconvenience, so if you would like us to be able to discuss your claim with someone else, for example your husband or wife, please write their name and their relationship to you below.

Name

Relationship to you

Medical certificate

In order to establish a claim, the claimant's medical attendant must complete this form as fully as possible in BLOCK CAPITALS. Any fee charged for completing this form is not covered by the policy.

Patient's name

How long have you been the patient's usual medical attendant? years months

Current illness

Please describe the symptoms / condition that the patient has

How long has the patient known of these symptoms?

When did you first see the patient about this illness? D D / M M / Y Y Y Y

History of these symptoms / this condition

Please give a full history of the condition, including any related symptoms / conditions, dates of all consultations, advice and treatment (including prescriptions). Please use extra paper if you need to.

Are more diagnostic tests or treatment needed?
If yes, please give details (including if the patient needs to be moved to receive the treatment or tests)

Declaration – to be completed by the patient's medical attendant or doctor

I declare that to the best of my knowledge and belief the information given in this medical certificate is true and complete.

Name

Address

Telephone

Fax

Email

Qualification

Signature

Date D D / M M / Y Y Y Y

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