

...peace of mind for whatever is beyond your horizon

Optical Claim Form

Are you covered? Where to send the claim form

It is important to check your policy to make sure that you are covered for the expenses for which you are claiming. If you are in any doubt as to what your policy covers, please feel free to contact our Helpline staff on:

T + 353 1 629 7140

Calls may be recorded or monitored for quality and training purposes.

F + 353 1 630 1306

E claims@alhealth.com

All claims correspondence should be sent to:

**à la carte healthcare claims
Allianz Worldwide Care Ltd
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland**

Policyholder & claimant details

Name of Policyholder (as shown on the Certificate of Insurance)

Policy Number

Name of Group (if applicable)

Name of claimant

Correspondence Address

 Postcode

Country

Date of birth (dd/mm/yyyy) Gender Male Female

Telephone Number Fax Number

Email Address

Amount claimed (continue on a separate sheet if necessary)

Description of Expense	Amount charged (please specify the currency)	Date of Test (dd/mm/yyyy)	Date of last Test (dd/mm/yyyy)
1) Eye examination carried out by an optometrist or ophthalmologist	<input type="text"/>	<input type="text"/>	<input type="text"/>
2) Prescribed glasses or contact lenses to correct vision	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total amount (please specify currency)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Allianz Worldwide Care Limited underwrite the risk and administer claims on behalf of à la carte healthcare limited.

Please note the following:

Where a currency conversion is required the rate will be that prevailing at the date of the invoice

Payment Details:

Payment to Policyholder Payment to Insured

Payment to be made in: Invoice currency Other currency (Please specify)

Preferred payment method: Cheque Bank transfer (Please fill in bank details)

Name of bank account

Account no./IBAN Sort/branch code

Swift code Bank name

Bank address

Postcode

Declaration

I declare that to the best of my knowledge all particulars contained in this form are true. I hereby give my permission for any Medical Practitioner/General Practitioner/Nurse/Optomtrist or Ophthalmologist, or other authority mentioned herein to release further information regarding my Dental records to à la carte healthcare limited and their appointed administrators. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Reports Act (AMRA) or other similar legislation. I understand that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for prosecution.

Data Protection Act

The Insurance Industry operates a number of anti fraud initiatives. The information on this form may be stored electronically and we may release certain information to other insurers or other interested parties. All data is maintained in accordance with the provisions of the Data Protection Act.

Signed (Policyholder/Claimant)

Date (dd/mm/yyyy)

(If patient is under 18 years, parent or guardian must sign)

Medical Certificate

To be completed by the attending Medical Practitioner/General Practitioner/Nurse/Optomtrist or Ophthalmologist. Any fee for completion of this form is the responsibility of the Policyholder/Claimant.

Optical

Details of eye test/correction to vision

Name and address of examining Optometrist/Ophthalmologist/Medical Practitioner or General Practitioner or Other

Postcode

Signature

Official Stamp

Date (dd/mm/yyyy)

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