International Healthcare
An april International brand

Cost Estimate Form

Please fill out the form with capital letters

MAi Medical Administrators International
Expatriates serving expatriates

This form, duly completed and signed, should be returned prior to admission to:

Medical Administrators International
21A One Capital Place
18 Luard Road, Wanchai
Hong Kong
Tel: +852 3516 8181

You can also send this form by:
1 - Scan and email to: hospi@medical-administrators.com
2 - Fax: +852 3585 0253

* Original invoices must be kept for a minimum period of 12 months. During this period, the Insurer reserves the right to ask for the original invoices.

* Please keep the original form for a minimum of 12 months. During this period the insurer reserves the right to ask for the originals at any time.

Cost estimate for the hospitalisation of: Mr. ☐ Mrs. ☐ Ms. ☐

Full Name of insured member ______

Personal reference number ______ / ______ Date of birth (dd-mm-yyyy) ______

Expected date of admission (dd-mm-yyyy) ______ Expected date of discharge (dd-mm-yyyy) ______

To be completed by the hospital and / or physician

Diagnosis and reason for admission[1][2] ______

Present Medical History / Current situation ______

Date of first symptoms ______ Date of first diagnosis ______

Principal Procedure / Type of surgery / Treatment ______

Follow-up plan and Discharge Medication ______

Name, address, tel/fax, email address of hospital, Name of contact person (For USA Hospitals: please also mention the area code)	Name, address, tel/fax of physician

Option A:	All-in rate = ______ /day	______ / total	
Option B: Type of room	Private	Semi-private	Ward
Hospitalisation expenses (e.g. medicines, x-rays, lab, etc)			
Doctor's fees [3] (for USA, please use CPT-code)			
Surgeon's fee			
Anesthetist's fee			
Others ______			
______			
______			
Total			

Should a letter of guarantee be sent to the above mentioned hospital? ☐ Yes ☐ No

In case of accident, please complete the "Notification of Accident Form".

Please attach a medical report.

Declaration: I hereby certify that the above information is true and correct to the best of my knowledge.
I certify that I have been made aware of the obligation to respond to the above questions and understand that incomplete or inaccurate answers would lead to the application of the Insurance Code article L 113-8 (contract nullity) or L 113-9 (benefits reduction). I undertake to communicate to the insurer information about the proposed insured and his dependents in strict compliance of the legislation on the processing of personal data in force.
This information may be disclosed to authorized professional bodies, as well as all those involved in the management and execution of this contract.
I have, as well as the members of the contract, the right to access and correct information concerning ourselves, with the Informations Clients Service - AXA 313 Terrasses de l'Arche 92727 Nanterre Cedex, France. The contract takes effect, subject to the payment of the premium, on the date stated in the policy schedule. This is based on the date of receipt of the application form and the results of the medical questionnaires and any medical reports. The decision of the insurer applies to all members under the same policy.

Date and signature of insured person [4]	Stamp of the hospital / Signature of physician

(1) All information subject to medical secrecy may be sent for the attention of our medical consultant in a sealed envelope.
(2) Diagnosis and medical reports should be legible and without abbreviations.
(3) In case of surgery, the fee of each member of the surgical team; in case of conservative treatment, the fee of the main treating physicians.
(4) In view of a smooth administration of the contract and / or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent regarding the processing of the medical data concerning myself and / or the members of my family.