

# Claim For Reimbursement Of Medical Expenses

For claims above € 500, US\$ 675 or CHF 750  
This form, duly completed and signed, should be returned to:  
**Medical Administrators International**  
**21A One Capital Place**  
**18 Luard Road, Wanchai**  
**Hong Kong**  
**Tel: +852 3516 8181**

For claims below € 500, US\$ 675 or CHF 750  
You can also send this form by:  
**1- Scan and email to: [aplus@medical-administrators.com](mailto:aplus@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 at any time.

TO BE COMPLETED BY THE PATIENT

## Policyholder / Employee

Pers. ref. no.: \_\_\_\_\_ / \_\_\_\_\_  
Last Name : \_\_\_\_\_ First name : \_\_\_\_\_  
Address : \_\_\_\_\_

## Patient

Last Name : \_\_\_\_\_ First name : \_\_\_\_\_  
Date of birth (d - m - y) : \_\_\_\_\_ Sex :  M  F

## Relationship

Self  Spouse  Child  Secondary dependant

Is the claim covered by another insurance?  Yes  No

If yes, please specify the amount reimbursed. : \_\_\_\_\_

Specify by which insurance. : \_\_\_\_\_

Is this the result of an accident?  Yes  No

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

## Amounts claimed per currency

***Diagnosis and full details of prescribed medicines (name and dosage) must be stated on the original bill and the claim form.***

Currency	Amount of expenses	Nature of expenses	Diagnosis	Date of 1 <sup>st</sup> symptoms (d - m - y)	Date of 1 <sup>st</sup> diagnosis (d - m - y)

Total: \_\_\_\_\_

Have you suffered from this or any related condition before?  Yes  No

If **yes**, please provide details separately.

## Mode of payment

- Reimbursement will be done by **cheque or bank transfer to your designated account**. Should you wish to modify instructions please contact us.
- Reimbursement is done in the currency of the policy.

## Hospitalisation

Date: \_\_\_\_\_

Diagnosis : \_\_\_\_\_

Treatment or operation : \_\_\_\_\_

**Please sign on the back**

### Claims document checklist

Before sending in this form, make sure that all claims are forwarded with supporting documentation to expedite the process of your claim

- Claim form completed by you with Membership number of patient and patient signature
- Payment receipts with
  - Patient's name
  - Treatment date
  - Diagnosis
  - Medical prescriptions
  - Drug prescriptions
  - Any medical reports or lab test results
  - Other documents justifying the expenses

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.

Policyholder's / Employee's signature: \_\_\_\_\_

Date: \_\_\_\_\_