SHORT-TERM & STUDENT INTERNATIONAL HEALTH PLANS

CLAIM FORM

Insurance made easy.

Please write in **CAPITAL LETTERS** and tick relevant boxes. Failure to complete the form fully will delay settlement of your claim. Please ensure you have read the 'how to make a claim' section of the Policy Guide prior to making a claim.

You must give us notice of a claim as soon as practicably possible after the start of treatment, even where original invoices are not yet available.

To help us deal with your claim promptly, please:
1. Complete a separate claim form for each person and each illness/accident/dental claim.
2. Ensure that the doctor or dentist who treats you fully completes the sections overleaf.
3. ALL questions must be answered in full (ticks or dashes will not be acceptable).
4. Original accounts for treatment received must be submitted.

The Assistance Company must be contacted for all claims under benefits requiring pre-authorisation and any claims likely to exceed £1,000/$1,700/€1,400. You will be responsible for 50% of treatment costs if you fail to obtain pre-authorisation before receiving treatment.

PATIENT INFORMATION (TO BE COMPLETED BY YOU/YOUR LEGAL REPRESENTATIVE)

A

1. Title: ○ Mr ○ Mrs ○ Ms ○ Miss ○ Other: .....
   Surname: .....
   First Name(s): .....
2. Date of Birth: d d / m m / y y y y
3. Certificate Number: .....
4. Gender: ○ Male ○ Female
5. Telephone:

6. Full Mailing Address: .....
   .....
   City: .....
   State/Region/County: .....
   Postcode:
   Country: .....
7. Email: .....

CLAIM INFORMATION (TO BE COMPLETED BY YOU OR YOUR LEGAL REPRESENTATIVE)

B

8. State the nature of the illness/symptoms:
   .....
   .....
9. Have you ever received treatment (including over the counter medication) for this condition or any related condition before this episode? ○ Yes ○ No
   If yes, please provide dates and details of previous treatment:
   .....
   .....
   .....
   .....
10. When did symptoms first occur?
    .....
11. If the cause of the illness relates to an accident, please state the date of the accident and give brief details of the circumstances and injuries received:
    Date: d d / m m / y y y y
    .....
    .....
    .....
12. Do you have any other insurance that provides cover for healthcare benefits? ○ Yes ○ No
    If yes, please provide details of the insurance policy:
    .....
    .....
    .....
13. Please complete the following table

Date of treatment	List expenses for which reimbursement claimed (Original accounts will be required)	State currency and amount paid	State in full, to whom you wish settlement paid*	Currency of settlement*

* Please complete section E, bank details, if applicable or not already supplied

14. Are further accounts to be submitted? ○ Yes ○ No
If so, please provide details:

.....

.....

.....

15. Is this a continuation of previous or current treatment for which you have already claimed under this plan?
○ Yes ○ No
If so, please provide details, including a claim reference number:

.....

.....

Ref: .....

B

16. Please provide the name and address of your usual General Physician:

Name: .....

Address: .....

City: .....

State/Region/County: .....

Postcode: | | | | | | | | |

Telephone: | | | | | | | | | | | | | |

Email: .....

17. Please provide details of other doctors and/or surgeons who have treated you for this or related conditions:

.....

.....

.....

18. April International UK handle claims on behalf of their underwriters; XL Insurance Company SE. CEGA Group have also been appointed to handle some claims. In order to process your claim we require your consent, you do have the right not to give consent, but if you do so we may not be able to process your claim. You are consenting to:

- April International UK reviewing the information in any additional medical reports or health records that may be requested in order to process your claim.
- April International UK sharing medical and health information with the underwriters and CEGA Group.

Please initial here to confirm your consent: | |

○ I wish to see any report from the doctor before it is sent to you (please see important information in section G)

It is important that you understand that any information, statements or answers made by you to us are your responsibility. You must take reasonable care not to make a misrepresentation when answering these questions.

I declare that the answers in this form and any other information provided are true and complete to best of my knowledge.

Signature of Patient (Parent/Guardian to sign if patient is under 16):

Date: d d / m m / y y y y

THE SECTION(S) BELOW MUST BE COMPLETED BY THE TREATING PHYSICIAN/DENTIST

MEDICAL INFORMATION (TO BE COMPLETED BY TREATING PHYSICIAN)

19. Please state the date on which the patient first consulted you for this or any similar or related condition:
Date: d d / m m / y y y y

20. Please describe the symptoms presented:

.....

.....

.....

.....

21. Please advise when these symptoms first occurred:

.....

22. Please detail your diagnosis of the illness/injury:

C

.....

.....

.....

.....

23. Please provide a detailed history including dates of this or any related medical conditions for which previous treatment and/or investigation took place:

.....

.....

.....

24. Is the condition likely to be considered congenital or a birth defect?
○ Yes ○ No
If yes, please provide details:

.....

.....

25. If all or part of the treatment was in respect of elective cosmetic surgery, please indicate the amount or the proportion of the costs involved:

.....

26. Please provide your name and address:

Name: .....

Address: .....

City: .....

State/Region/County: .....

Postcode: | | | | | | | | |

Telephone: | | | | | | | | | | | | | | |

Email: .....

Signature of treating physician:

Date: d d / m m / y y y y

Qualifications: .....

ROUTINE DENTAL TREATMENT INFORMATION (TO BE COMPLETED BY TREATING DENTIST)

27. Has the patient attended for a routine check-up in the past 12 months and was all necessary treatment concluded?
○ Yes ○ No

28. In your opinion has the patient maintained good dental hygiene? ○ Yes ○ No
If not, please provide details:

.....

.....

.....

29. Please describe the dental necessity for this claim:

.....

.....

.....

30. Please provide your name and address:

Name: .....

Address: .....

City: .....

State/Region/County: .....

Postcode:

Telephone:

Email: .....

Signature of treating dentist:

Date: d d / m m / y y y y

Qualifications: .....

D

BANK DETAILS

Please note that our bank requires the BANK SWIFT/BIC number AND the BANK IBAN number for ALL International Transfers of Funds.

Name of bank: .....

Bank address: .....

.....

City: ..... State/Region/County: .....

Postcode: Country: .....

Account holder: .....

Account number:

Sort Code (UK only):

BIC/Swift Code:

IBAN No:

E

SUBMITTING THE FORM

Please submit the completed claim form along with the supporting invoices and/or receipts by post to:
April International UK, Minster House, 42 Mincing Lane, London, EC3R 7AE United Kingdom

If the claim is less than £1,000/$1,700/€1,400 you can submit the claim form and copies of the invoices and/or receipts by email to:
claims@april-international.co.uk

You must retain the original documents as we have the right to request them.

F

IMPORTANT INFORMATION

Access to medical reports Act 1988
Before giving your consent to us obtaining a Medical Report, you should read the following information as it sets out your rights under the above act

- When dealing with your claim, we may need to apply for a medical report from a doctor who has treated you. We need your consent to apply for a report.
- You do have the right not to give consent, but if you do so we may not be able to process your claim.
- If we need a report we will write to you to tell you the date it was requested.
- If you allow us to seek a medical report from a doctor who has treated you, you can indicate in the box above if you wish to see the report (or have a copy of it) before it is sent to us. If you would like to see the report, you will have 21 days to contact the doctor about arrangements for you to see the report. If the 21 days lapses and these arrangements have not been made then the doctor will send us the report.
- If you disagree with the information in the report, you can contact the doctor to change it. If the doctor does not agree with you, they will ask you to write a statement which includes your views and this will be attached to the report.
- The doctor does not have to show you parts of the medical report if they think it could causes harm to your physical or mental health.
- If the doctor does not want you to see part of their report, they will tell you in writing, but you can still view other parts of the report.
- You can ask the doctor to see the report at any time within six months of the doctor sending it to us.
- Your doctor may charge you for a copy of the report. This charge is not covered by your policy.

Continued over...

G

IMPORTANT INFORMATION

Data Privacy
For full information about how we process and protect your personal information please refer to our Privacy Policy which can be viewed by clicking on the site terms and conditions on our website **www.april-international.com**.

How We Use Your Information
The personal information, provided by you (or anyone acting on your behalf), is collected by or on our behalf and may be used by us, our employees, agents and service providers acting under our instruction for the purposes of insurance administration, underwriting, claims handling, insurance mediation, research or for statistical purposes.

We may process your information for a number of different purposes. For each purpose we must have a legal ground for such processing. When the information that we process is classed as 'special category data, we must have a specific additional legal ground for such processing.

Generally, we will rely on the following legal grounds:

- It is necessary for us to process your personal information to provide this policy and services related to it. We will rely on this for activities such as providing you with information about your quote, assessing your application, managing your policy, handling claims and providing other services to you.
- We have an appropriate business need to process your personal information and such business need does not cause harm to you. We will rely on this for activities such as maintaining our business records, developing, improving our products and services, and providing information about our products and services to you.
- We have a legal or regulatory obligation to use such personal information.
- We need to use such personal information to establish, exercise or defend our legal rights.
- You have provided your consent to our use of your personal information, including special category data.

How we share your information
In order to sell, manage and provide our products and services, prevent fraud and comply with legal and regulatory requirements, we may need to share your information with the following types of third parties:

- Insurers, Reinsurers, Regulators and Authorised/ Statutory Bodies
- Fraud prevention agencies
- Crime prevention agencies, including the police
- Suppliers carrying out a service on our behalf
- Other insurers, business partners and agents
- Other companies within the APRIL Group

As we operate as part of a global business, we may transfer your personal information outside the European Economic Area (EEA) for these purposes where adequate protection is in place.

Marketing
We will not use your information or pass it on to any other person for the purposes of marketing further products or services to you unless you have consented to this.

Fraud Prevention and Detection
In order to prevent or detect fraud and money laundering we may check your details with fraud prevention agencies and sanction websites, who may record a search. Searches may also be made against other insurers' databases. If fraud is suspected, information will be shared with those insurers. Other users of the fraud prevention agencies may use this information in their own decision making processes.

We may also conduct credit reference checks in certain circumstances. You can find further details in our full Privacy Policy explaining how the information held by fraud prevention agencies may be used.

Automated Decisions
We may use automated tools with decision making to assess your application for insurance and for claims handling processes. If you object to an automated decision, we may not be able to offer you an insurance quotation.

Contact Us
Please contact us if you have any questions about our privacy policy or the information we hold about you

Please note that APRIL International Care has authority from the insurers to handle claims on their behalf subject to certain limitations. If you do not wish us to act on this claim as an agent of both yourself and insurers, you should advise us by return and we will arrange for handling of your claim to be managed by insurers themselves.

APRIL International Care France
4 rue Gerty Archimède - 75012 Paris - FRANCE
www.april-international.com

A French simplified joint-stock company (S.A.S.) with capital of €200,000 - RCS Paris 309 707 727
Insurance intermediary - Registered with ORIAS under number 07 008 000 (www.orias.fr)
Prudential Supervision and Resolution Authority - 4 place de Budapest - CS 92459 - 75436 PARIS CEDEX 09 - FRANCE
NAF6622Z - VAT N° FR603009707727

Insurance made easy.