Health Insurance Claim Form

Please ensure that all of the sections of this form are completed. Where a section is not applicable, please indicate as such by using the symbols N/A. **Payment of claims may be delayed or refused as a result of incomplete or illegible information**. This form must be returned to Citadel Insurance p.l.c. within 60 days from date of first treatment. Please enclose the original invoices, receipts and relevant documents for this claim and keep a copy of all original documents, as these will be retained by the Company.

SECTION 1: MEMBER DETAILS

Subscriber Name		ID No:	DB: DD/MM/YYYY
Patient's Name		ID No:	DB: DD/MM/YYYY
Policy No./Group Name (where applicable)		Contact No:	Email:
Address:			

SECTION 2: GENERAL INFORMATION

	Yes	No	Additional Information / Details
Is your claim the result of an accident or work-related illness/injury?			
Are you covered for medical expenses with any other insurance? If yes, please provide details:			
Have you previously claimed for this medical condition?			
Medical condition / please provide details:			
Date you first became aware of symptoms/medical condition:	Date: Day	Month	Year

SECTION 3: ASSESSMENT DETAILS

PART A - General Practitioner / Gynaecologist / Paediatrician Assessment

Patient Name:			
Medical Condition:			
Type of Condition:	◯ Acute	◯ Chronic	◯ Acute episode of chronic
When were symptoms of this condition first noticed by the patient?	Date: Day	Month	Year
First consultation date for the medical condition:	Date: Day	Month	Year
Does the medical condition need long term monitoring, consultations, check-ups or tests? If yes, please specify:		◯ Yes	◯ No
Treatment and diagnostic tests required or performed:			
Prescribed drugs:			
Is the patient currently undergoing any other treatment or taking medication for any other condition? If yes, please specify:		◯ Yes	◯ No

I am referring the patient to the following Specialist / Consultant / Therapist / Treatment:

Medical Practitioner's Stamp:		*If not already detailed in the Stamp:* Name: Email Address:
Signature:	Date:	Contact No:

PART B - Specialist Assessment

All specialist consultations must be referred by your GP.

Details of symptoms/medical condition:	
Treatment and Diagnostic tests recommended or performed and any prescribed drugs:	
Signature & official stamp:	Email:
	Tel:
	Date: DD/MM/YYYY

PART C - Details of In-Patient / Day-Patient Treatment

You should always contact us before receiving any in-patient or day-patient treatment so we can confirm the extent of cover under your plan and the eligibility of your claim.

Signature & official stamp:	Hospital/Clinic:
	Admission date: DD/MM/YYYY

SECTION 4: NUMBER OF DOCUMENTS ATTACHED TO YOUR CLAIM FORM

Original receipts:	Test results:	Medical reports:	Hospital case summary/discharge letter:
Blood test results:	Prescriptions:	Other (please specify):	

SECTION 5: DECLARATION AND DATA PROTECTION NOTICE

Declaration: I hereby declare that to the best of my knowledge and belief, the information provided on this form is true and complete. I understand and accept that Citadel may decline my claim if I do not fully disclose material facts. In circumstances where a claim is deemed to be fraudulent my policy may be cancelled, and I will be notified in writing.
Data Protection: I am reminded that Citadel Insurance p.l.c. ("the Company") may collect medical information from insurance companies, doctors and other members of the medical profession, hospitals, clinics, laboratories and medical facilities. The information obtained will pertain to my/my dependant's health and would therefore be necessary for the claim to be assessed.
I understand that the information that is provided in respect of this claim is processed by Citadel for the same purposes outlined in the Data Protection Notice that was made available to me in the Policy document and/or with the insurance certificate, and shall be subject to the same terms and conditions stipulated therein. In short, the Company will use the data for the purpose of performing its obligations under the insurance contract, and may also use the data to abide by its legal obligations and to safeguard its legitimate interests. The data may be disclosed, only as is strictly necessary, with the Company's employees, officers, intermediaries, external consultants and advisors, and other insurance and reinsurance companies, among others. The data is kept only for as long as it is necessary according to the purposes for which it was collected. I/we, as a data subject, have the right to access my/our data, amend it to the extent that it is inaccurate, object to direct marketing, request the erasure of data, or to have the data transferred to another controller, among other rights. The full Data Protection Notice may be requested at any time, and is available on the Company's website www.citadelplc.com.

Patient Signature
(OR subscriber's signature if patient is under 18 years of age) _____ Date: DD / MM / YYYY

SECTION 6: PAYMENT INSTRUCTIONS

Please complete your bank details below in order to receive payment directly into your bank account. By doing so all your and minor dependants' future claim payments will be credited to this account number. We can only make payments to bank accounts that are within the Single Euro Payments Area (SEPA).

☐ Please cancel my previous instructions and send payments to the bank account details on this form.

Account Holder Name: _____ BIC / SWIFT code: _____

IBAN number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please send notification of payment to this e-mail address: _____

Patient signature: _____ Date: DD / MM / YYYY
(OR subscriber's signature if patient is under 18 years of age)

The above information will be processed by Citadel to provide you with the direct credit service. Such information will not be shared with third parties unless for the purpose of providing you with a comprehensive service. For further information, please refer to the privacy policy on our website, https://www.citadelplc.com/en/privacy-policy.

DEFINITIONS:
Treatment: Medical services that are needed to diagnose, relieve or cure a medical condition. These include consultations or advice, diagnostic tests or scans, therapy, surgery, and use of drugs.
Specialist: A licensed medical practitioner possessing the qualifications and expertise to practice as a recognised specialist in the field of medicine for which the insured requires treatment.
Medical Condition: A disease, illness or injury that requires treatment in accordance with generally accepted medical practices.
Medical Practitioner: A nurse, general practitioner, specialist, physician, surgeon, anaesthetist, complementary medicine practitioner, therapist or dental practitioner who provides active treatment of a known medical condition, who is registered and licensed by a competent authority to practice medicine in the country where the treatment is provided.
Prescribed drugs: A pharmaceutical drug that is permitted to be dispensed only to those with a medical prescription.

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