



MAPFRE Middlesea p.l.c.
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Registration Number: C5553

Health Insurance Claim Form

IMPORTANT NOTES

A referral by your General Practitioner prior consultations with specialists, therapists and any diagnostic procedures is recommended, except for consultations/treatment given by gynaecologists, paediatricians or ophthalmologists. You must always contact MAPFRE Middlesea p.l.c. before receiving planned in-patient treatment, C.T./M.R.I. scan, to enable us to confirm eligibility and extent of cover. Claims, together with original receipts, to be submitted within 3 months of initial date of treatment.

1. INSURED/PATIENT'S DETAILS

Title:	
(Sur)name of policyholder:	
I.D. card no.:	Date of birth of policyholder:
Title:	
(Sur)name of patient:	
I.D. card no.:	Date of birth of patient:
Address:	
Tel/Mob. no.:	Policy no.:
E-mail:	
Group/Company name (if applicable):	

2. TO BE COMPLETED BY THE PATIENT/LEGAL GUARDIAN

Reason for seeking medical advice:		
Date of patient's first visit to any doctor for this condition:		
Did treatment require in-patient treatment? YES <input type="checkbox"/> NO <input type="checkbox"/>		
If the answer is "YES" please advise:	Admission date:	Discharge date:
Attach hospital certificate(s) (if applicable):		
Are any of the costs recoverable from a third party? YES <input type="checkbox"/> NO <input type="checkbox"/>		
If "YES", give details:		

3. TO BE COMPLETED BY A REGISTERED MEDICAL OR DENTAL PRACTITIONER

Patient's name:
Details of the medical condition/symptoms:
Diagnosis:

Date of first consultation with the GP for this medical condition:
Treatment given:
Treatment recommended:
Does the patient require further treatment from a specialist? YES <input type="checkbox"/> NO <input type="checkbox"/>
Date:
Signature of General Practitioner:

4. TO BE COMPLETED BY A SPECIALIST

Patient's name:
Details of the patient's complaints/symptoms:
Diagnosis:
Treatment given:
Treatment recommended:
Date:
Signature of Specialist:

DECLARATION

I authorise MAPFRE Middlesea p.l.c. to share information with others (including insurers and Insurance Associations) in order to prevent fraudulent claims. I declare that all the answers given and the statements made are true and correct. Furthermore I declare that I have not withheld any information relevant to the claim. I give explicit and unequivocal consent to MAPFRE Middlesea p.l.c. to seek any information from any doctor, surgeon, hospital, clinic, laboratory or persons that have records or knowledge of my health in order for the validity of the claims to be established.

I hereby authorise any doctor, surgeon, hospital, clinic, laboratory or persons that have records to provide full medical information concerning myself and my dependants.

I give consent to MAPFRE Middlesea p.l.c. to process my personal data supplied by myself or any person, body or entity in order to process, handle and settle the claim.

Date:
Patient's signature (If the patient is under 18 years of age, then the legal guardian must sign):

DATA PROTECTION

MAPFRE Middlesea p.l.c. is legally bound to follow the provisions of the Data Protection Act, 2001. MAPFRE Middlesea p.l.c. is registered with the Office of the Commissioner for Data Protection to process data in accordance with this Act. The Data Protection Policy of MAPFRE Middlesea p.l.c. is compliant with this Act, a copy of which is available on request.

MAPFRE Middlesea p.l.c. (C-5553) is authorised by the Malta Financial Services Authority to carry on both Long Term and General Business under the Insurance Business Act, 1998.