



Medical and Dental Claim Form

To ensure swift payment of your claim please ensure you provide the following:

- > A fully completed claim form
- > A contact number and email address so that we may contact you should further details be required
- > Check that the bank details provided are correct
- > Please state the currency which you would prefer your payment to be in
- > Payments by cheque will be sent to the 'correspondence address' which you provide on this form
- > List your expenses separately in the columns in Section B and include all relevant details of your invoices/receipts

If you have any queries regarding your claim, please contact our Customer Service Line:

Tel: +353* 46 90 77 377

For members in the USA call Toll Free:

1 800 852 7747

Email: vhi.international@intana-assist.com

+ First dial the international access code.

* When dialling from the Republic of Ireland, omit 353 and first dial 0.

This form and original invoices and receipts to be sent to:

Vhi International Claims Department,
Collinson Insurance Services Limited,
IDA Business Park, Athlumney,
Navan,
Co. Meath,
Ireland.

Medical and Dental Expenses Claim Form

- Step 1** You should complete Sections A and B (Please complete in block capitals)
NOTE WE MAY NEED TO CONTACT YOUR MEDICAL PROVIDER FOR FURTHER DETAILS
- Step 2** Please ensure that you submit this form within 3 months of the start of your treatment as claims received after this date will not be considered.

Section A – Policyholder/patient details

Mr Mrs Ms Miss Other _____ First Name: _____ Surname: _____

Date of Birth: _____ Policy No: _____

Correspondence Address For This Claim: _____

Contact Number (including country code): _____ Email Address: _____

Name of Patient (if different from Policyholder): _____

By completing the next section(s), you confirm that Collinson Insurance Services Limited trading as Intana has your full authority to remit monies directly to the account indicated by the BACS or other electronic banking system. You also accept that, providing payment is remitted to the bank account designated by you, Intana shall have no further liability or responsibility in respect of such payment, and that it shall be your sole responsibility to make collection of any misdirected payment.

If you have had a previous claim paid electronically and you would like the same account to be used again, please tick this box and enter the last 4 digits of your IBAN

If you would like payment to be made by electronic transfer into a new or different account, please complete the following section:

Bank Name: _____

Address: _____

Country of Bank: _____

Account Holder Name: _____

IBAN:

SWIFT/BIC Number: BSB (Australia only):

For speed of payment, settlement by Bank Transfer is advisable, however should you require payment by cheque please tick here.

Section B – Details of illness/condition and expenses incurred To be completed by the policyholder/patient

Is this a continuation of a previous claim? Yes No

Describe in your own words the nature of your illness/condition: _____

Is this claim related to an accident? Yes No

Do you have any other private medical insurance policies? Yes No

When did you first start to experience the signs and symptoms of this illness/condition? Day Month Year

What date did you first see any doctor/dentist for this illness/condition? Day Month Year

Please give details of your usual family doctor/dentist; First Name: _____ Surname: _____

Address: _____

GP Contact No. (including country code): _____

If treatment was received in your home country, please confirm your travel dates; Date of return to your home country: Day Month Year
Date of departure from your home country: Day Month Year

Please give details of all receipts/invoices included with this claim (continue on a separate sheet of paper if necessary)

| Date of receipt/invoice | Details of expense | Currency of amount paid | Amount paid | Specify currency of settlement |
|-------------------------|--------------------|-------------------------|-------------|--------------------------------|
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| Date of receipt/invoice | Details of dental expense | Tick | Currency of amount paid | Amount paid | Specify currency of settlement |
|-------------------------|-----------------------------|------|-------------------------|-------------|--------------------------------|
| | Emergency Treatment | | | | |
| | Wisdom Teeth Extraction | | | | |
| | Extraction Non-Wisdom Teeth | | | | |
| | Filling | | | | |
| | X-Rays | | | | |
| | Crowns | | | | |
| | Root Canal | | | | |
| | Annual check up / hygienist | | | | |
| | Other | | | | |

Section C

Data Protection Statement

In order to adjudicate on your claim, Vhi and Intana will process the personal data you have provided on this form, together with any personal data that you have authorised third parties to provide to us. Certain processing of your personal data is required in order for us to adjudicate on your claim and for us to be able to operate the business of providing international insurance policies.

Vhi Healthcare DAC of Vhi House, Lower Abbey Street, Dublin 1 ("Vhi"), and Collinson Insurance Services Limited trading as Intana, of IDA Business Park, Athlumney, Navan, County Meath ("Intana"), and Astrenska Insurance Services Limited, Cutlers Exchange, 123 Houndsditch, London, EC3A 7BU ("the Insurer"), are the companies that control and are responsible for processing the personal data in relation to your claim. We will process your personal data in accordance with the Vhi Data Protection Statement which has previously been provided to you. If you would like another copy of the Vhi Data Protection Statement it is available at Vhi.ie, or you can request a copy by calling us on **(056) 444 4444** or **1890 44 44 44**.

Obtaining Additional Information

In order to process and to establish the eligibility and appropriateness of your claim we will, **as appropriate**:

- Contact the facility and your treating practitioners (including, where relevant, your GP) on your behalf to request a copy of all necessary information including, if requested, copies of the facility/medical records relating to the treatment and/or services received by you as part of this claim.
- Approach any third party who holds information relating to the incident giving rise to this claim and obtain from them such information as is required to assist in the investigation and resolution of this claim.
- Share information with other insurers or financial institutions for the purposes of dealing with this claim and eliminating insurance fraud.

Where it is necessary, we will ask you to allow the treating practitioners to share your information with us.

Please deal solely with myself in respect of this claim:

Or

Authorisation for Broker/Other Third Party - optional:

I hereby authorise (name of broker or other third party)

to handle this claim on My/Our behalf and agree that all communications in respect of the claim will be solely through them.

Declaration

I declare that the information completed above at the time of signing this declaration is true in every respect. I authorise Intana on behalf of the Insurer to pay the appropriate benefits, for services provided, to the treatment facility and medical practitioners concerned. I understand that the details of these amounts will be included in my settlement statement and I will contact Intana directly with any queries. Charges which are not eligible for benefit will remain my responsibility to settle directly with the treatment facility/medical practitioner concerned.

Important - you must sign here:

Patient's (or Parent/Legal Guardian if patient is under 18 years)* Signature:

Date:

**For claims in relation to a dependant under 18 years at the time of signing this form, please note that all correspondence and relevant payments will be made to the policyholder.*

Please check that you have entered your Policy Number:

Please note that the address you provide is purely for data validation purposes. If you need to update your contact details or membership/personal data, please contact our Customer Services Helpline at **(056) 444 4444** or **1890 44 44 44**.

Vhi Healthcare DAC trading as Vhi Healthcare is regulated by the Central Bank of Ireland. Vhi Healthcare is tied to Collinson Insurance Services Limited for International Health Insurance, which is underwritten by Astrenska Insurance Limited.

Check List:

If all requested information is not supplied we will not be able to process your claim.

Before submitting your claim please ensure:

- All relevant documentation outlined on page 1 has been submitted with this claim.
- All supporting documentation are originals (we recommend that you retain copies).
- This claim form has been fully completed and signed.

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