Global Health Insurance

XN Global Solutions

Claim Form

CHECKLIST

1. A fully completed **Claim** form, ☐
2. All invoices relating to the **Treatment** received and proof of payment, ☐
3. **Your** bank details so that **We** can process the transfer of the reimbursement **Claim**, ☐
4. If applicable, the letter of referral by a **Medical Practitioner** or **Specialist**. ☐
5. If applicable any medical records, diagnostic test results or discharge reports. ☐

Please note that if any of the above is missing or incomplete, **We** will not be able to process **Your Claim**.

IMPORTANT INFORMATION

Please complete the **Claim** form in BLOCK CAPITALS and submit it to **Us** within one hundred and eighty (180) days of the **Treatment** date.

A separate **Claim** form is required for each patient and for each **Medical Condition**.

For continuous **Treatment** that spreads across from one contract **Period of Cover** to a new contract **Period of Cover We** will require a new **Claim** form to be submitted by **You**.

Should **You** receive **Treatment** for a **Benefit** that requires **Pre-Authorisation** from **Us** but do not seek approval, **We** will only pay **Reasonable and Customary Charges** for any **Eligible Treatment**.

For any **Claim** under USD $ / EURO €500 in value **We** will not require the treating **Medical Practitioner** to sign and stamp this **Claim** form.

Please keep a copy of the original documents in case they should be required by **Us**.

You can track the progress of **Your Claim** online via **Your** secure online member portal; using **Your** username and unique password.

Should **You** require further clarification about this **Claim** form or any aspect of **Your** cover, please do not hesitate in contacting **Our** customer service team via email at xnglobalclaims@xn.com or via the **Claims** hotline number on + 1 8774699797.

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1 Insured Person and Patient Information

To be completed by **You**.

Planholder Name:	**Policy Number:**
Insured Person / Patients Name:	**Date of Birth:**
Email Address:	
Reason for Doctors visit/Diagnosis: (Please specify symptoms)	
Country Where Treatment took place:	**Treatment Date:**
Medical Practitioner / Hospital Details and Address	

Currency of Claim Incurred In:	**Currency You would Like to be Reimbursed In:**
Total Claimed Amount:	**Type of Service:** ☐ In-Patient, ☐ Day-Patient, ☐ Out-Patient, ☐ Dental, ☐ Maternity, ☐ Optical, ☐ Medical Check-Ups.

Is the Claim Due to an Accident or Injury? ◯ Yes ◯ No

If Yes, please provide information and the date of the Accident or injury:

Third Party Insurance

If some of the costs of **Your Claim** are recoverable from a third party (For example the **Benefits You** are claiming for are in relation to a **Medical Condition** or **Accident** or Injury caused by a person or organisation or if **You** have another Insurance **Policy** which covers, **You** for this **Claim**) please provide details below:

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2 Medical Information for Claims over USD $ / EURO €500

To be completed by the treating **Medical Practitioner**.

Medical Condition:

Diagnosis / ICD Code:

Details of underlying cause:

When did the patient first see a doctor: (dd/mm/yyyy)

Details of Treatment/Medication:

Details of Surgical Procedures (If any):

Procedure Code (If applicable):

Hospital Details (Name and Address):

Admission Date (If applicable):

Discharge Date (If applicable):

Medical Practitioner Declaration

☐ I declare that I am the patient's **Medical Practitioner**, and that the details given are to the best of my knowledge true, correct, and accurate.

Print Name:	**Official Stamp**
Signature:	
Date (dd/mm/yyyy):	

3 Bank Account Information

Please provide **Your** bank account information so that we can reimburse **You** for **Your Eligible Claim Expenses**.

Account/Payee Name		**IBAN Number**	
Name of Bank		**Routing Code***	
Branch Address and Country		**Intermediary Bank Details***	
Bank Account Currency		**Branch Code***	
Account Number		**Swift Code***	
Local Banking Code*			

**Please use NA if not applicable.*

Please note that on occasion **You** may incur a charge levied by **Your** own bank for incoming international bank transfers and that international bank transfer can take between seven (7) to ten (10) days for the funds to appear in **Your** bank account, which **We** have no control over.

4 Data Protection

Pursuant to the Regulations (EU) 2016/679 of 27 April 2016 on the protection of individuals concerning the processing of personal data and on the free movement of such data (known as General Data Protection Regulation) and for the purpose of the management of the insurance contract, the personal data of the **Primary Insured Person** and their **Dependants** if any, are jointly processed by the **Insurer**, **XN Europe** and Henner.

The **Primary Insured Person** are informed that processes concerning them, and their **Dependants** if any, are implemented for the signing, management and execution of this insurance contract throughout its commercial management. Personal data may also be processed for control operations, in the fight against fraud and money laundering and the financing of terrorism, for production of statistics and actuarial studies, management of **Claims** and disputes, improvement of the quality of services and the relationship with the **Insured**, management of websites and applications and management of requests for the exercise of rights.

This personal data may be transferred to other entities of **XN Europe** or the Henner Group or to service providers or subcontractors which are established in countries outside of the European Union. If this personal data is not transferred to countries recognised by the European Commission as providing an adequate level of personal data security, such transfers are governed by standard contractual clauses of the European Commission or by all other legal instruments, thus guaranteeing a level of protection as high as in France.

The **Primary Insured Person** and their **Dependants** if any, have a right of access, rectification or deletion, limitation of the processing of their data, portability, opposition to processing, or, where appropriate, withdraw their consent at any time, along with the right to provide instructions on the outcome of the data after their death. They can exercise their rights by contacting **XN Europe, Délégué à la Protection des Données (Data Protection Officer), Conformité/Relation Assureurs or by email**: privacy@xn.com. In the event of a persistent conflict, they have the right to appeal to the **CNIL** on www.cnil.fr or at **3, place de Fontenoy - TSA 80715 - 75334 PARIS CEDEX 7, FRANCE**.

To learn more about the processing of personal data of the **Primary Insured Person** and their **Dependants** if any, by the **Insurer**, **XN Europe** and Henner and to exercise their rights, the **Primary Insured Person** and their **Dependants**, if any can, refer to the **XN Europe** Insured GDPR Charter available on the member portal.

5 Authorisation

I understand and hereby authorise **XN Europe**, the Henner Group and its service providers or subcontractors to request all necessary medical information needed to process my **Claim** and/or those of my **Dependants** from the above medical facility or treating **Medical Practitioner.** The authorisation is valid for ninety (90) days from the date on which it was signed. I also understand that I can rescind this authorisation at any time by sending an email to xnglobalclaims@xn.com which would prevent the assessment and processing of my **Claim**.

6 Declaration

I hereby declare that I am the patient or the guardian of the patient, if the patient is under eighteen (18) years of age.

I wish to **Claim** for **Benefits** under my **Solutions Policy** and declare the information I have given is, to the best of my knowledge true, correct, and accurate.

I understand that it is unlawful for me to knowingly provide false, inaccurate, or misleading facts or information (**Reluctance or Misrepresentation)** to **XN Europe**, the Henner Group and its service providers or subcontractors for the purpose of defrauding or attempting to defraud **XN Europe** or the **Underwriters**. Penalties may include denial of coverage, loss of or increase in premium, loss of **Benefits** and legal damages.

Signature (Insured Person/Patients Name): **Date (dd/mm/yyyy):**

X

Note:

Please note that **XN Europe** will not pay for the release of medical records or reports as per the **Administrative Costs** exclusion under the defined **Policy** terms and conditions.

Please upload this completed and signed form to **Your Claim** submission from **Your** member portal.