health program medica supports life

CLAIM FORM
OUTPATIENT BENEFIT MEDICA POLICY

PART A – To be completed by the Policy Owner (for an Individual Policy) or the Main Insured (for a Group Policy) and the Insured Patient

Policy Owner's Name: _____ Policy No.: _____

Main Insured's Name (only for a Group Policy): _____

Policy Owner/ Main Insured's ID No.: _____ Policy Owner/Main Insured's email: _____

Policy Owner/Main Insured's Phone No.: _____ Policy Owner/Main Insured's Mobile No.: _____

Insured Patient's Name: _____ Insured Patient's ID No.: _____ Insured Patient's Date of Birth: _____

Insured Patient's Phone No.: _____ Insured Patient's Mobile No.: _____

Illness Symptoms: _____ Date of First Symptoms: _____

Did the Patient suffer from this illness in the past? ☐ YES ☐ NO If YES, When?: _____

DECLARATION

I hereby declare responsibly that all the information provided with this claim form, is true and complete.

Full Name and Signature of Insured Patient*: _____ Date: _____

** To be signed by the Parent/Legal Guardian of any Insured Patient under 18 years old.*

Full Name and Signature of Policy Owner (for an Individual Policy) or Main Insured (for a Group Policy):

_____ Date: _____

PROCESSING OF SPECIAL CATEGORIES OF PERSONAL DATA

For the purposes of examining and executing your claim submitted herewith (the "Claim"), as well as for the purposes of ensuring compliance with the terms of the policy for which you are an insured person ("the Policy"), we will be required to process special categories of data ("Sensitive Data"). The processing of Sensitive Data refers exclusively to your health information as an insured person and is limited to information that is necessary for the examination and execution of the Claim and/or for the evaluation of adherence to the terms of the Policy.
Recipients of Sensitive Data are relevant members of our staff and the staff of Mednet S.A. (the independent health claims administrator with which we collaborate) as well as our, relevant to your claim, associates/partners, that are subject to an obligation of confidentiality. The Recipients of your Sensitive Data may also be the Policy Owner if this is a different person.
Please note that you have the right to withdraw your consent to the processing of your Sensitive Data at any time. In such a case however, we may not be able to process your Claim. Further information on your rights with regard to your personal data, as well as with regard to the handling of your data by us, can be found in the Full Privacy Statement that is available on our website www.eurolife.com.cy under the heading "Communications/FAQ's and Forms".
With your signature below, you hereby give explicit consent to the processing of Sensitive Data (that is, data relating to your health) for the abovementioned purposes.

Full Name & Signature of Insured Patient*: _____ Date: _____

* To be signed by the Parent/Legal Guardian of any Insured Patient under 18 years old.

PART B - To be completed by the Attending Physician

Patient's Name: _____ Age: _____

Diagnosis (if it is a pregnancy when did it approximately start?) _____

Which are the patient's symptoms? _____

When did they first appear? _____ Date of accident (if valid): _____

Dates of previous visits (related to this medical condition): _____

Medical and Diagnostic Exams carried out and When: _____

Prescription

Do you recommend further X-rays, laboratory tests or other treatment? _____

If this concerns surgery, please provide details: ☐ Inpatient /clinic ☐ Outpatient

Date of surgery: _____ Hospital / clinic which was conducted: _____

Is this the first time the patient has received treatment for this illness / injury? ☐ YES ☐ NO

If NO, when was the first incident and how was it treatment? _____

ATTENDING PHYSICIAN'S DECLARATION

I hereby declare that to the best of my knowledge and belief, the answers to the above questions are complete and accurate.

Physician's Full Name: _____ Phone Number: _____

Specialty: _____ Stamp & Physician's Signature: _____ Date: _____

For the faster processing of your claim, please ensure that all fields of the Claim Form are completed and accompanied by all required supporting documentation. For any assistance you may require, please contact Mednet at 22463033.

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