

Section 1

Insured/Patient's Details and Description of Symptoms

1. Name and I.D. card number (policyholder)

name

I.D. card

2. Name and I.D. card number (patient)

name

I.D. card

3. Date of birth (policyholder & patient)

policyholder

patient

4. Address

5. Tel/Mob. number and e-mail address

6. Policy number and group name (if applicable)

policy number

group

7. Describe your symptoms

8. If in-patient treatment was required, give dates

admitted

discharged

9. If any of your conditions were caused by a third-party, give details (eg. car accident)

10. Could these costs be claimed under another policy?

details of other insurance policy

Section 2

To be completed by a registered Medical or Dental Practitioner

1. Patient's name

2. Details of patient's complaint/symptoms

3. Diagnosis

4. Date of first consultation with any GP for this condition

5. Treatment given today

6. Future treatment recommended

7. Patient referred to a specialist

Yes

No

8. Name and signature of general practitioner

name

date

signature

Section 3

To be completed by a Specialist

1. Patient's name

2. Details of patient's complaint/symptoms

3. Diagnosis

4. Treatment given today

5. Future treatment recommended

6. Name and signature of specialist

name

date

signature

Patient's Signature

(If the patient is under 18, the Legal Guardian must sign)

I declare that I have read; and that I understand and I agree with the claim notes and declaration on the overleaf of this sheet.

signature

date

Important Notes

- Claims for specialist consultation and any diagnostic procedures must be on the initial recommendation of your General Practitioner, except for consultations or treatment given by gynaecologists, paediatricians or ophthalmologists.
- You must always contact Laferla Insurance Agency Limited before receiving any in-patient treatment, C.T./M.R.I. scan, to enable us to confirm eligibility and extent of cover.
- Claim forms, together with original receipts and supporting documents such as test results or case summary reports, are to be submitted within 3 months of initial date of treatment.

Declaration and Data Protection

I authorise Laferla Insurance Agency Limited 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 Laferla Insurance Agency Limited 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 my consent to Laferla Insurance Agency Limited to process my personal data supplied by myself or any person, body or entity in order to process, handle and settle the claim.

Laferla Insurance Agency Limited is legally bound to follow the provisions of the Data Protection Act, 2001. Laferla Insurance Agency Limited is registered with the Office of the Commissioner for Data Protection to process data in accordance with this Act. The Data Protection Policy of Laferla Insurance Agency Limited is compliant with this Act a copy of which is available on request.

Payment Details

If you would like settlement by Bank Transfer, please fill in Sections 4-6 below. If the payee for this claim is NOT the policyholder please also fill in Sections 1-3.

1. Name and I.D. card number of payee

<input type="text"/>	<input type="text"/>
<i>name</i>	<i>I.D. card</i>

2. Address of payee

3. Relation of the payee to the policyholder and patient

4. Bank Name and Address

5. IBAN

6. SWIFT/BIC Code

Laferla Insurance Agency Limited (C-14529) are agents for Middlesea Insurance plc (C-5553). Both companies are authorised by the Malta Financial Services Authority.



LAFERLA

INSURANCE AGENCY LIMITED

LAFERLA HEALTHPLANS claim form

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For office use only

Date Received