Health Insurance Claim Form

Citadel insurance

All relevant sections of the claim form must be completed. The claim form, original receipts, copies of test results and other relevant documentation must be sent to us within 2 months of the initial treatment date. We recommend that you retain a copy of all documentation you send to us for your own records; we will be unable to return original documents but would be happy to provide copies on request.

SECTION 1: MEMBER DETAILS

Subscriber details	Title:	Name:	Surname:
Group name (where applicable):		ID No:	DB: DD/MM/YYYY
Patient details	Title:	Name:	Surname:
Policy No:		ID No:	DB: DD/MM/YYYY
Tel:		Mobile:	Email:
Address:			

SECTION 2: GENERAL INFORMATION

Medical condition you are claiming for:

Date you first became aware of symptoms/medical condition DD/MM/YYYY | Have you previously claimed for this medical condition? Yes ☐ No ☐

Is your claim the result of an accident or work-related illness/injury? Yes ☐ No ☐

Are you covered for medical expenses in part or in full from any other source? Yes ☐ No ☐

If you have answered Yes to any of the above, please give details:

SECTION 3: DECLARATION & DATA PROTECTION NOTICE

Declaration: I hereby declare that to the best of my knowledge and belief, the information provided on this form is true and complete. I understand and accept that Citadel may decline my claim if I do not fully disclose material facts. In circumstances where a claim is deemed to be fraudulent my policy may be cancelled, and I will be notified in writing.

Data Protection: I am reminded that Citadel Insurance p.l.c. ("the Company") may collect medical information from insurance companies, doctors and other members of the medical profession, hospitals, clinics, laboratories and medical facilities. The information obtained will pertain to my/my dependant's health and would therefore be necessary for the claim to be assessed.

I understand that the information that is provided in respect of this claim is processed by Citadel for the same purposes outlined in the Data Protection Notice that was made available to me in the Policy document and/or with the insurance certificate, and shall be subject to the same terms and conditions stipulated therein. In short, the Company will use the data for the purpose of performing its obligations under the insurance contract, and may also use the data to abide by its legal obligations and to safeguard its legitimate interests. The data may be disclosed, only as is strictly necessary, with the Company's employees, officers, intermediaries, external consultants and advisors, and other insurance and reinsurance companies, among others. The data is kept only for as long as it is necessary according to the purposes for which it was collected. I/we, as a data subject, have the right to access my/our data, amend it to the extent that it is inaccurate, object to direct marketing, request the erasure of data, or to have the data transferred to another controller, among other rights. The full Data Protection Notice may be requested at any time, and is available on the Company's website www.citadelplc.com.

Patient Signature
(OR subscriber's signature if patient is under 18 years of age) _____ Date: DD / MM / YYYY

SECTION 4: PAYMENT INSTRUCTIONS

Please complete your bank details below in order to receive payment directly into your bank account. By doing so all your and minor dependants' future claim payments will be credited to this account number. We can only make payments to bank accounts that are within the Single Euro Payments Area (SEPA).

☐ Please cancel my previous instructions and send payments to the bank account details on this form.

Account Holder Name: _____ BIC / SWIFT code: _____

IBAN number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please send notification of payment to this e-mail address: _____

Patient signature: _____ Date: DD / MM / YYYY
(OR subscriber's signature if patient is under 18 years of age)

The above information will be processed by Citadel to provide you with the direct credit service. Such information will not be shared with third parties unless for the purpose of providing you with a comprehensive service. For further information, please refer to the privacy policy on our website, https://www.citadelplc.com/en/privacy-policy.

SECTION 5: ASSESSMENT DETAILS

Part A - General Practitioner assessment

Patient name:	Type of condition: Acute ☐ Chronic ☐ Acute episode of chronic ☐

Details of symptoms/medical condition:

Date when symptoms would first have been apparent: DD/MM/YYYY	Date of initial consultation: DD/MM/YYYY

Has the patient suffered from this condition in the past? If Yes, please give details:

Does the condition need long term monitoring, consultations, check-ups or tests? If Yes, please give details:

Treatment prescribed, including drugs:

Is the patient currently undergoing any other treatment or taking medication for any other condition? If Yes, please give details:

Signature & official stamp	Email:
	Tel:
	Date: DD/MM/YYYY

Part B - Specialist assessment

All specialist consultations must be referred by your GP. We make an exception for consultations with gynaecologists/paediatricians.

Details of symptoms/medical condition:

Treatment prescribed, including drugs:

Signature & official stamp	Email:
	Tel:
	Date: DD/MM/YYYY

Part C - Details of in-patient / day-patient treatment

You should always contact us before receiving any in-patient or day-patient treatment so we can confirm the extent of cover under your plan and the eligibility of your claim.

Signature & official stamp	Hospital/Clinic:
	Admission date: DD/MM/YYYY

SECTION 6: NUMBER OF DOCUMENTS ATTACHED TO YOUR CLAIM FORM

Original receipts:	Test results:	Medical reports:	Hospital case summary/discharge letter:
Blood test results:	Prescriptions:	Other (please specify):	

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