



## 2 Claim/medical details

(all sections must be completed by the Medical Practitioner in overall charge of the patient's treatment where possible, otherwise it should be completed by member)

In which country did the treatment take place?

What is the currency of the invoice?

What is the total amount of the claim?

### Medical Details

Reason for treatment / visit to medical practitioner, such as your symptoms and diagnosis if known

Is the treatment related to

Wellness/preventative

Maternity

Oncology

Dental

Opticians (correct a sight/vision)

Onset date when symptoms first noticed by patient

D D M M Y Y Y Y

When did the patient first see a doctor?

D D M M Y Y Y Y

Details of treatment received, including operations and medications

### Medical Practitioner's details

Name

Speciality/Qualifications

Medical facility name

Address

Email

Telephone (Please include country code, area code and number)

### Hospital admission details (if applicable)

Admission date

D D M M Y Y Y Y

Discharge date

D D M M Y Y Y Y

Hospital name

Address

Email

Telephone (Please include country code, area code and number)

Medical practitioner's signature

Date

D D M M Y Y Y Y

Print Name

### 3 Cash benefit

The hospital should complete this section if there were no charges for your overnight admission, and your plan includes a cash benefit

I confirm that .....  
 was in hospital from ..... to .....  
 and this admission was free of charge

The hospital needs to stamp this claim form here:

### 4 Payment details

#### Important information

We can settle claims in over 80 currencies. This must be in one of the following; (i) the currency in which you pay your premium (ii) the currency of the invoices you send us or (iii) the currency of your bank account.

Who would you like us to pay? (select one only)

Doctor <input type="radio"/>	Hospital/Clinic <input type="radio"/>	Patient/Member (enclose proof of payment) <input type="radio"/>	Group/Company (enclose proof of payment) <input type="radio"/>
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Please complete either Section A or Section B note that reimbursement can only be made via these payment methods.

#### Section A - Payment by Electronic Funds Transfer to a bank account

Bank name	
SWIFT / BIC code*	
Sort code (UK only)	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>
Account number	
Full IBAN number*	
Account name / payee	
Currency for the transfer	
Bank address	
Post / Zip code	
Country	

**\*To process your payment as quickly and securely as possible, we strongly recommend this option as a preferred payment method. Please provide both your IBAN and the SWIFT code of your bank branch. Your bank will be able to provide you with this information if necessary.**

We recommend that bank transfers are made in the currency of your bank account. If you submit a claim and have asked us to pay you, your benefit will be paid less the amount of deductible or co-insurance applicable to your plan. If you have asked us to pay the provider, and an annual deductible or co-insurance applies to your cover, the shortfall will be collected using your direct debit or credit card. If you are part of a company plan, we will send payment to the medical provider for the eligible claim. We will deduct from this payment the remaining annual deductible or co-insurance on your membership. You are responsible for paying any shortfall to the provider after your claim has been assessed and paid. To find out if you have a co-insurance or deductible on your plan, please refer to your membership certificate. To find out more about how co-insurances and deductibles work please refer to your membership guide.

#### Section B - Payment by cheque

In which currency would you like us to pay the cheque (please select one only)

Currency of your invoices  Currency of your premiums  Currency of your bank account  Other, please specify:

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## 5 Third party insurers

Are some of the costs recoverable from someone else (for example, state insurer or a person / organisation involved in an accident?)

Y  N

Name

Address

Email

Telephone (Please include country code, area code and number)

## 6 Your local insurer details

Name

Address

Phone number

Membership number

Valid from  D  D  M  M  Y  Y  Y  Y Expiry date  D  D  M  M  Y  Y  Y  Y

Supplemental cover  Y  N

Name

Address

Phone number

Membership number

Valid from  D  D  M  M  Y  Y  Y  Y Expiry date  D  D  M  M  Y  Y  Y  Y

Have you already notified KVG/your supplemental cover provider of this claim?  Y  N

If you hold KVG cover or supplemental cover, you declare that you, and any additional persons named under your plan, have not made and will not make any claim against Bupa, where such claim may be made against your KVG insurer or your local supplemental cover. You, and any of the additional persons named under your plan, agree that Bupa and your KVG insurer or supplemental cover, as the case may be, may exchange information pertaining to your claim, including information on your personal health.

Signature

Date

Print Name

## 7 Your consent to obtain a medical report

### Important information

In order to process your claim, we may need to apply for a medical report from any doctor who has attended you. To apply, we need you to give your consent by signing the declaration below.

**Please read this section carefully, as it sets out your rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (NI) Order 1991.**

**If you receive treatment in the UK, you can choose from three courses of action.**

1. You can give your consent without asking to see the doctor's report before it is sent to us. The report will then be sent directly to us by the doctor.
2. You can give your consent, but ask to see any report before it is sent to us, in which case you will have 21 days, after we notify you that we have requested a report from the doctor, to contact your doctor to make arrangements to see the report. If you fail to contact the doctor within 21 days, they will be entitled to send the report direct to us. If however you contact your doctor with a view to seeing the report, you must give the doctor written consent before they can release it to us. You may ask your doctor to change the report if you think it is misleading. If your doctor refuses, you can insist on adding your own comment to the report before it is sent to us. Should you give your consent to us obtaining a report without indicating that you wish to see it, you can change your mind by contacting your doctor before the report is sent to us, in which case you will have the opportunity to see the report and ask the doctor to change the report or add your comments before it is sent to us, or withhold your consent for its release.
3. You can withhold your consent but, if you do, please bear in mind that we may be unable to accept your claim. Whether or not you indicate that you wish to see the report before it is sent, you have the right to ask your doctor to let you see a copy, provided that you ask them within six months of the report having been supplied to us. Your doctor is entitled to withhold some or all of the information contained in the report if (a) they feel that it may be harmful to you or (b) it would indicate their intentions in respect of you or (c) would reveal the identity of another person without their consent (other than that provided by a health professional in their professional capacity in relation to your care). Your doctor may also make a reasonable charge for their services. The undersigned authorises and requests any hospital, specialist, physician or other health provider to furnish Bupa or its duly authorised agent acting on Bupa's behalf with such information as Bupa or that agent may seek from them in connection with any treatment or other services provided to me or my dependant for the purpose of Bupa considering this claim.

**If you are receiving treatment in the UK, by signing this form you are confirming that:**

I have been advised of my rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (NI) Order 1991.

**If you receive treatment in the UK please indicate below if you wish to see a copy of the medical report before it is sent to Bupa:**

I do wish to see a copy of any medical report before it is sent to Bupa.

I do NOT wish to see a copy of any medical report before it is sent to Bupa.

## 8 Privacy notice

Last updated: March 2022

We are committed to protecting your privacy when dealing with your personal information. This privacy notice provides an overview of the information we collect about you and how we use and protect it. It also provides information about your rights. The information we process about you, and our reasons for processing it, depends on the products and services you use. You can find more details in our full privacy notice available at: [www.bupaglobal.com/privacypolicy](http://www.bupaglobal.com/privacypolicy). If you do not have access to the internet and would like a paper copy of the full privacy notice, or if you have any questions about how we handle your information, please contact the Bupa Global service team on +44 (0) 1273 323 563. Alternatively, you can email or write to the team via [info@bupaglobal.com](mailto:info@bupaglobal.com) or Bupa Global, Victory House, Trafalgar Place, Brighton BN1 4FY, United Kingdom.

### Information about Bupa Global

In this privacy notice, "we" "us" and "our" means the Bupa companies trading as Bupa Global. For details of these companies visit [www.bupaglobal.com/legal-notices](http://www.bupaglobal.com/legal-notices) The Bupa companies that process your information will depend on which of our products and services you ask us about, buy or use. For our insurance policies, your information will be processed by the insurer and the lead administrator of your policy who may share it with other Bupa companies as set out in the 'Sharing your information section'. Please refer to your policy documentation for confirmation of the insurer and lead administrator.

### 1 What this privacy notice covers

This privacy notice applies to anyone who interacts with us about our products and services ("you", "your"), in any way (for example email, website, phone, app and so on).

### 2 How we collect personal information

We collect personal information from you and from other organisations (for example those acting on your behalf, like brokers, healthcare providers and so on). If you give us information about other people, you must make sure that they have seen a copy of this privacy notice and are comfortable with you giving us their information.

### 3 Categories of personal information

We process the following categories of personal information about you and, if it applies, your dependants. This is standard personal information (for example information we use to contact you, identify you or manage our relationship with you), special categories of information (for example health information, information about race, ethnic origin and religion that allows us to tailor your care), and information about any criminal convictions and offences (we may get this information when carrying out anti-fraud or anti-money-laundering checks or other background screening activity).

### 4 What we use personal information for and our legal reasons for doing so

We process your personal information for the purposes set out in our full privacy notice, including to deal with our relationship with you (including for claims and complaints handling), for research and analysis, to monitor our expectations of performance (including of health providers relevant to you) and to protect our rights, property, or safety, or that of our customers, or others. The legal reason we process personal information depends on what category of personal information we process. We normally process standard personal information on the basis that it is necessary so we can perform a contract, for our or others' legitimate interests or it is needed or allowed by law. We process special categories of information because it is necessary for an insurance purpose, because we have your permission or as described in our full privacy notice. We may process information about your criminal convictions and offences (if any) if this is necessary to prevent or detect a crime.



### Claim checklist

Please review the following checklist and ensure that the information and supporting documents are provided, where applicable:

- Clear, readable and unobscured documents (photocopied receipts should not obscure any details, clear handwriting, etc)
- Symptoms and/or diagnosis, where this has been established, along with the onset date
- Prescription for pharmacy and optical claims
- Final itemised invoice to include treatment dates, description and cost of each service provided (please note we cannot accept interim or estimate invoices)
- A medical/discharge report, for inpatient treatment and surgical procedures
- Complete payment instructions including payment currency
- Proof of payment for member/group/company paid claims
- Signature, name and date provided for the declaration above

Please, note that we may need to request additional information to complete the assessment of your claim.

If you can provide this information directly, we will contact you by email to advise the full details, which you can also view in your MembersWorld account.

**Members: You will be able to track the progress of your claim on our MembersWorld website (<https://membersworld.bupaglobal.com>)**

# Notes