

Claim form

Important information

To make a claim, simply complete the questions on this form and return it to:
GlobalCapital Health Insurance Agency Limited, Testaferrata Street, Ta' Xbiex XBX 1403, Malta.

For pre-authorising treatment or for questions when completing this form please call us on 21 342 342.

Please ensure that all sections of the claim form are fully completed in block letters. Note that claims' payment may be delayed if all sections are not completed in full. Ensure that you always enclose original invoices and receipts - photocopies/credit card vouchers are not acceptable. Clinic fees and waiting room fees are not refundable. Treatment must be on initial referral of the family doctor.

Please complete a new/separate claim form for:

- each patient
- each in-patient/day-case stay
- each medical condition
- each currency

This form should be returned to us immediately or within three months of the initial treatment.

1. Principal member's details (to be completed by the principal member)

Membership number	<input type="text"/>	Group (if applicable)	<input type="text"/>
Name and surname	<input type="text"/>	ID number	<input type="text"/>
Address	<input type="text"/>	Telephone	<input type="text"/>
<input type="text"/>		Mobile	<input type="text"/>
<input type="text"/>		Email	<input type="text"/>

2. Patient's details (to be completed by the patient undergoing treatment)

Membership number	<input type="text"/>	Name & surname	<input type="text"/>
ID number	<input type="text"/>	Date of birth	<input type="text"/>
Telephone	<input type="text"/>	Occupation	<input type="text"/>
Mobile	<input type="text"/>	Email	<input type="text"/>
Symptoms for seeking medical advice <input type="text"/>			
Onset date of symptoms first noticed by patient <input type="text"/>			

Are some of the costs recoverable from someone else? ☐ Y ☐ N

(For example another insurer or a person/organisation involved in an accident. If the answer is 'yes' please give details in a covering letter.)

3. Payment details (we can now settle eligible, valid claims via direct credit to the principal member's bank account)

Please ignore this section if you have already provided Bupa Malta with your bank details.

All payments in respect of claims for treatment under this membership will be credited to the below mentioned bank account unless otherwise advised by the principal member.

Bank name	<input type="radio"/> APS	<input type="radio"/> Banif	<input type="radio"/> BOV	<input type="radio"/> HSBC	<input type="radio"/> Lombard	<input type="radio"/> Other	<input type="text"/>
(Tick one only)							
Account holder's name	<input type="text"/>						
Bank account number	<input type="text"/>						
Account holder's signature	<input type="text"/>					ID number	<input type="text"/>
Preferred payment details notification method	<input type="radio"/> Email	<input type="radio"/> SMS	(Tick one only)				

4. Family doctor (to be completed by the family doctor)

Patient's name and surname		
Details of symptoms, diagnosis/condition		
Onset date when symptoms first noticed by patient		Has patient been treated for this condition before? <input checked="" type="radio"/> Y <input type="radio"/> N (if yes, when?)
Drugs prescribed, investigations or treatment required		
What other treatment/medication is patient currently taking?		
Details of specialist/therapist to whom patient has been referred to		
How long have you been the Family Doctor of this patient?		Telephone
Family Doctor's signature and stamp		Email
		Date

5. Specialist/therapist (to be completed by the referred specialist)

Patient's name and surname		
Details of symptoms, diagnosis/condition		
Onset date when symptoms first noticed by patient		Has patient been treated for this condition before? <input checked="" type="radio"/> Y <input type="radio"/> N (if yes, when?)
Drugs prescribed, investigations or treatment required		
Specialist/therapist signature and stamp		
		Telephone
		Email
		Date

6. In-patient and day-case treatment (to be completed by hospital/clinic official)

Hospital/clinic		Admission/discharge date	
Signature of hospital official and hospital stamp		Date of operation	
Who would you like us to pay?	<input type="radio"/> Hospital	<input type="radio"/> Consultant	<input type="radio"/> Principal member (Tick one only)

7. Your consent to obtain medical report

Important information - please read this carefully

The undersigned authorises and requests any hospital/clinic, specialist, physician or other health provider to furnish GlobalCapital Health Insurance Agency Limited, or its duly authorised agent acting on GlobalCapital's behalf, with such information as GlobalCapital or that agent may seek from them in connection with any treatment or other services provided to me or my dependant's for the purpose of GlobalCapital considering this claim.

Data Protection Notice

Purpose: Personal data collected on you, and where appropriate your family, will be used by GlobalCapital and Bupa to process your claims, administer your policy. It may be used to detect and prevent fraud or improper claims.

Confidentiality: The confidentiality of patient and member information is of paramount concern to GlobalCapital and Bupa. To this end GlobalCapital and Bupa fully comply with Data Protection legislations and guidelines and other legislation concerning client confidentiality.

Member details: All membership documents and confirmation of how we have dealt with a claim you may make will be sent to the principal member.

Fraud: Information may be disclosed to others with a view to preventing fraudulent or improper claims.

Medical information: Medical information will be kept confidential. It will only be disclosed to those involved in your treatment or care, including your Family Doctor/Primary Health Physician or their agents, and if applicable, to any person or organisation that may be responsible for meeting your treatment expenses or their agents. Claims information may be discussed with GlobalCapital Insurance Intermediary/Advisor where you have requested the Advisor to assist you.

Keeping you informed: Bupa Malta is brought to you by GlobalCapital Health Insurance Agency Limited. Bupa and GlobalCapital p.l.c. subsidiaries would, on occasion, like to keep you informed of products and services which it considers may be of interest to you.

Contact Address: If you do not wish to receive this information, or have any other Data Protection queries please write to the Customer Services Manager, GlobalCapital Health Insurance Agency Limited, Testaferata Street, Ta' Xbiex XBX 1403, Malta, email bupa@globalcapital.com.mt or Bupa Group Head of Information Governance, at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA, United Kingdom, email DataProtection@BUPA.com

8. Declaration (to be completed by the patient)

I confirm that the information I have given on this form is accurate and correct, to the best of my knowledge.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, to process my personal information with respect to this claim.

Patient's signature (parent or guardian if patient is under 18)	Date

If you have any queries regarding your claim, please contact our Customer Services Department on 21 342 342.

GlobalCapital Health Insurance Agency Limited (GCHIA) acts as a branch of Bupa Insurance Limited, which has passported its services through the European Passport Rights for Insurance and Reinsurance Undertaking Regulations. GCHIA is registered as an Insurance Agent and is regulated by the Malta Financial Services Authority. Registered office: GlobalCapital p.l.c., Testaferata Street, Ta' Xbiex XBX 1403, Malta.