CLAIM FORM

GasanMamo Insurance, Msida Road, Gżira, GZR 1405, Malta.

GasanMamo INSURANCE
We're always there

Please read carefully

- Please ensure that all sections of the claim form are completed in BLOCK CAPITALS and that you sign and date the back of the form.
- Treatment must be on initial referral of your General Practitioner.
- Eligible fees will be paid up to the limits of your policy and up to the maximum amounts we consider to be fair and reasonable.
- Claim forms must be submitted together with original receipts and an itemised list of all tests being carried out within 3 months from the date of treatment.
- Always contact us before receiving any treatment.
- If you have any queries, please call GasanMamo on +356 2134 5123 or email sana@gasanmamo.com

Please complete a new/ separate claim form:

- For each patient
- For each out/ in/ day-patient treatment
- For each medical condition

1 Policyholder/ Patient details

Policyholder's Name & Surname		Passport/ I.D. No.
Patient's Name & Surname		Passport/ I.D. No.
Policy number	Group/ Company name (if applicable)	
House name/ No.	Street	
Town	Postcode	Tel. No.
Mobile No.	Email	
Reason for seeking medical advice		
Have you previously claimed for this medical condition? Yes ☐ No ☐	Date when symptoms started	
Are you covered for medical expenses under any other insurance policy? Yes ☐ No ☐	If yes, give details below	

2 Medical examination

General Practitioner's details		
Name of patient	Date of consultation	
Name of GP		General Practitioner's signature & stamp
Date symptoms first noticed by patient		Reg. No.
Has the patient been treated for this condition before? Yes ☐ No ☐		GP Tel. No.
Diagnosis/ Symptoms/ Treatment		
	Referred to	

Specialist's/ Therapist's details (patient has to be referred by the GP above)		
Name of patient	Date of consultation	
Name of Consultant		Specialist's/ Therapist's signature & stamp
Date symptoms first noticed by patient		Reg. No.
Has the patient been treated for this condition before? Yes ☐ No ☐		Consultant Tel. No.
Diagnosis/ Symptoms/ Treatment		
	Referred to	
Date of operation	Procedure code/s	

Hospital/ Clinic details		
Name		
Admission date	Discharge date	Signature of Hospital Official

3 Direct Credit Details

Kindly complete your bank details below if you would like to receive payment of your claim directly into your bank account. If you have already given us your details, you are not required to complete this section again unless you would like to make changes to the existing bank account details. We can only make SEPA payments in euro.

Account Holder's details		
Name & Surname		Passport/ I.D. No.
Address		
Town/City	Country	Email Address
Bank Account details		
Name of Bank	Country	
IBAN No.		
BIC code	Date	Account holder's signature

4 Declaration (To be signed by the patient)

In view of the declaration below it is essential that complete information is supplied.

It is GasanMamo's intention to provide a good service to our policyholder at all times. However, if you have any cause for dissatisfaction please write to the Managing Director, GasanMamo Insurance Limited, Msida Road, Gżira GZR1405. The law of Malta will apply to this contract unless you and us agree otherwise.

I understand that benefits may not be payable if I do not fully disclose any material facts which could influence GasanMamo's assessment and acceptance of my claim. I agree to disclose facts even when I am in doubt as to whether they are material and relevant.

Processing your data

I give explicit and unqualified consent to GasanMamo Insurance Ltd. within the provisions of the Professional Secrecy Act 1994 and the Data Protection Act 2001 to obtain and make use of any personal information relating to myself and my dependants in order to allow GasanMamo to process this claim.

To the extent that the information supplied, whether orally or in writing, constitutes personal data, including sensitive data within the provisions of the Data Protection Act, I consent to the processing of such data for purposes of administering my proposal for insurance, my policy, underwriting, handling of claims and also for the purposes of detecting, preventing and suppressing fraud and of keeping statistics.

We may be required to collect further information from our tied intermediaries, other insurance companies, insurance intermediaries or insurance associations. In addition, we may seek further information from any doctor, hospital, clinic, laboratory or any related practitioner to provide us with further medical information. This helps us to check the information provided. When you tell us about an incident which may or may not give rise to a claim, we may pass information relating to it to the Malta Insurance Association, other insurance companies, tied intermediaries, brokers, or medical advisers for the purpose shown in the declaration.

You have the right to request access to, and rectification of, your personal data held by us by directing your request in writing signed by yourself to the Data Protection Officer, GasanMamo Insurance Ltd, Msida Road, Gżira GZR1405.

Important - Please read

- Claims payment may be delayed if all the sections of the form are not completed in full.
- This form MUST be returned to us completed immediately following treatment or within three months of the treatment date.

Always enclose original invoices and receipts – photocopies and credit vouchers are not acceptable.

I declare that to the best of my knowledge and belief, the information given on this form is true and complete. I understand and accept that in the event of this claim form being fraudulent in whole or in part, the policy may be invalidated.

Patient's signature/ Parent or guardian's signature if the patient is under 16.	Date