

# Claim Form

Return this form together with original invoices to:  
GlobalCapital Health Insurance Agency Limited, 120, The Strand, Gzira GZR 1027

**BUPA**  
Malta

is brought to you by  
**GlobalCapital**

## Please read these notes carefully

Treatment must be on initial referral of your General Practitioner.

In order to make the most of your membership, please ensure you pre-authorise your treatment by calling BUPA Malta First on 21 342 342.

Please ensure that all sections of the claim form are fully completed in BLOCK CAPITALS.

Please ensure you sign the section at the back of the form.

### Please complete a new/separate claim form:

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

## 1 Subscriber's details - to be completed by the member

|                                   |                            |          |                   |  |
|-----------------------------------|----------------------------|----------|-------------------|--|
| Title                             | First Name                 | I.D. No. |                   |  |
| Other Initials                    | Surname                    |          |                   |  |
| Date of birth Day                 | Month                      | Year     | Age last birthday |  |
| House Number/Name                 | Street                     |          |                   |  |
| Town                              | Postcode                   |          |                   |  |
| Tel No – Day <b>21</b>            | Tel No – Evening <b>21</b> |          |                   |  |
| Is this address temporary? Yes No | Mobile No                  | Email    |                   |  |

## 2 Patient's details - to be completed by the person undergoing treatment

|                           |                                    |          |                   |  |
|---------------------------|------------------------------------|----------|-------------------|--|
| Title                     | First Name                         | I.D. No. |                   |  |
| Other Initials            | Surname                            |          |                   |  |
| Date of birth Day         | Month                              | Year     | Age last birthday |  |
| Patient Membership number | Group/Company Name (if applicable) |          |                   |  |

## 3 Examination by your General Practitioner / Specialist

### General Practitioner's details

|  |                                  |
|--|----------------------------------|
| Name   | General Practitioner's signature |
| Date   |                                  |
| Treatment given and why the patient had to be referred to a specialist |                                  |

### Specialist's / Therapist's details (applicable when the patient has been referred by the above GP)

|                         |                                      |
|-------------------------|--------------------------------------|
| Name                    | Specialist's / Therapist's signature |
| Date                    |                                      |
| Diagnosis and condition |                                      |

|  |                     |   |     |    |
|--|---------------------|---|-----|----|
| Date symptoms first noticed by patient | D D / M M / Y Y Y Y | Has the patient been treated for this condition before? | Yes | No |
|--|---------------------|---|-----|----|

|  |  |
|--|--|
| Details of treatment and/or prescribed drugs |  |
|--|--|

|                   |                     |
|-------------------|---------------------|
| Date of operation | Procedure code OPCS |
|-------------------|---------------------|

### Hospital / Clinic details

|      |                |             |                |             |
|------|----------------|-------------|----------------|-------------|
| Name | Admission date | D D M M Y Y | Discharge date | D D M M Y Y |
|------|----------------|-------------|----------------|-------------|

## 4 Payment Details

|                  |                  |
|------------------|------------------|
| Payee            | Name             |
| Bank Details     | Name             |
| Bank Address     |                  |
| Tel No <b>21</b> | Fax No <b>21</b> |
| Account Number   | Sort Code        |

Payments will be made by electronic transfer when bank account details are provided. This payment method and banking of cheques may result in charges by your bank, which are your responsibility.

We reserve the right to send any benefit due to an appropriate person for example, the executors of the will of someone who has died or the dependant on your membership who has paid the bill.

## 5 Your consent for us to obtain a medical report

### PLEASE READ THIS SECTION 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 for the purpose of GlobalCapital considering this claim.

### GlobalCapital Health Insurance Limited

#### Data Protection Notices

**Purpose:** Personal data collected about you, and where appropriate your family, will be used by GlobalCapital 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. To this end GlobalCapital fully complies with Maltese Legislation and guidelines and other legislation concerning client confidentiality.

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

**Fraud:** Information may be disclosed to others with a view of 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 General Practitioner/ 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 the GlobalCapital Health Insurance Agency Ltd Agent/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. Other GlobalCapital divisions would, on occasion, like to keep you informed of products and services, which they consider may be of interest to you.

**Contact Address:** If you do not wish to receive information about GlobalCapital or have any other data protection queries, please write to the Customer Services Manager at GlobalCapital Health Insurance Agency Limited, 120, The Strand, Gzira GZR 1027 or send an email to [bupa@globalcapital.com.mt](mailto:bupa@globalcapital.com.mt)

Should you be interested in receiving promotional material and/or information via telephone, mobile phone automated calling machine, facsimile machine and electronic mail please tick this box

|  |     |    |
|--|-----|----|
| Are some of the costs recoverable from someone else (for example, another insurer or a person/organisation involved in an accident)? | Yes | No |
| If your answer is yes, please let us have full details in a covering letter.   |     |    |

### IMPORTANT PLEASE READ

- Please note that claims payment will be delayed if all the sections of the form are not completed in full.
- This form MUST be returned to us immediately following treatment or within three months of the treatment date.
- Clinic fees and waiting room fees are not refundable.
- Always enclose original invoices and receipts - photocopies and credit card vouchers are not acceptable.
- If the condition persists for more than 3 months we may request a new claim form to be completed.

## 6 Declaration (to be completed by the patient)

I declare that, to the best of my knowledge and belief, the information given by me in this form is true and complete. I do give explicit and unqualified consent to GlobalCapital, 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 me in order to allow GlobalCapital to process this claim.

**Patient's signature / Parent or guardian if the patient is under 18.**

|           |      |
|-----------|------|
| Signature | Date |
|-----------|------|

**If you have any queries about your claim, please contact our  
Customer Services Department on Tel. No. (+356) 21 342 342**