Global Protective Solutions[SM]

Insurance & Services for Medical Tourism

Claims Process & Instructions

We are sorry you have experienced a loss. We want this claim process to go smoothly, so we are providing the details that will make processing the claim easier.

Your insurance coverage is provided by **Optimum Global Insurance Company Limited**

Please report all claims with details to:

Optimum Global Insurance Company Limited
Telephone: +44 (0) 1444 473405
Mail Address: 21 Perrymount Road, Haywards Heath, West Sussex. RH16 3TP. United Kingdom.
Email: claims@optimumglobal.com

If you have a medical emergency, seek medical assistance where you are. Please do not defer emergency medical treatment whilst contacting Claims Processing. However, other non-emergent claims should be approved prior to charges being incurred or your maximum benefit could be limited to $1,000, per the terms of coverage.

For claims processing, please complete this form and return to the above Claims Processing email with the requested attachments. You will need to complete the attached Claim Report in full for your claim to be reviewed and your paid expenses considered for reimbursement.

In addition to the Claim Report, you may be asked for other documentation for assessment. Relevant supporting medical evidence may be requested for consideration of your reimbursement.

Normal response time for you to receive acknowledgement following receipt of your claim is 2 working days. Following this, normal response time to begin settlement is 2 weeks. More complicated situations may require additional time.

Please note, to fully assess your coverage and consider your claim for reimbursement, certain documentation will be required. Any known omission of relevant details and or failure to provide requested documentation for benefit consideration in a timely manner can result in claim denial and closure.

If you have a situation involving a hospital or other medical provider requesting a guarantee of payment, or if your condition, whilst not an emergency, requires direct attention, you may contact the Claims Processing email or phone number above during business hours of 9 am to 5 pm GMT (UK Time).

EMERGENCY ASSISTANCE

If you need emergency assistance, please contact the assistance service:

Healthcase Services
24/7 phone contact: +1 (305) 893-9433 (USA)
Email: hcserv@healthcaseservices.com

Assistance Services include:

- Emergency Medical Transportation Services and Repatriation
- Family Coordination Services
- Medical and Dental Referrals

This is available 24 hours a day, 7 days per week and is staffed by rotating multi-lingual professionals. After assisting you, they will assign your case to their Claims personnel for routine handling.

Claim Submission Form

Medical & Related Expenses for Medical Travel Claims

Program Policy # _____

Enrollment Verified _____

For Claims Handler Use Only

Please complete this claim form completely and return it to:

Optimum Global Insurance Company Limited
21 Perrymount Road, Heywards Heath
West Sussex RH16 3TP United Kingdom
claims@optimumglobal.com
+44 (0) 1444 473405

Insured Details

Title	Full Name	Date of Birth	Occupation	Usual Country of Domicile

Insured Address: _____

_____

_____ Postcode: _____

Telephone: _____ E-mail: _____

Mobile: _____ (E-mail may be used for correspondence if stated)

Travel Details

Dates of Travel for Medical Procedures:

Departure Date: ____/____/_____ Return Date: ____/____/_____

Purpose of Trip, if other than for Medical Treatment: ❑ Business ❑ Pleasure

Travel Destination: Country: _____City: _____

Name of Hospital for your Medical Travel Treatment:_____

Address: _____

Hotel, if applicable: _____

Claim Details

Date, time and place of illness/injury: ____/____/_____ ____:____ ☐AM☐PM

_____

Treating Doctor(s):_____

Illness suffered or injuries sustained: _____

_____

_____

If injury, please provide full circumstances of the incident – Attach a separate sheet if necessary:

_____

_____

_____

Have you suffered from a similar condition before? ❑ Yes ❑ No

If yes, we reserve the right to obtain further details from prior treatments.

For EU Nationals did you present your EHIC? (EU countries only) ❑ Yes ❑ No

If yes, we reserve the rights to obtain claim settlement details for this instance.

Do you hold any other insurance that may cover this loss? ❑ Yes ❑ No

(i.e. Public, Private Health, Bank Account, Credit Card, Tour Operator)

If yes, please give details:

Name of Company_____

Address: _____

Did you contact Assistance Service for this incident? ❑ Yes ❑ No

If yes, please provide the reference number given to you:_____

Please provide the details of the hospital, clinic, doctor you saw for treatment related to this claim:

Name of Hospital for treatment of this Illness or injury: _____

Address: _____

Hotel, if applicable: _____

Date(s), time and place(s) treatment of an illness/injury incurred during your medical travel:

____/____/_____ ____:____ ❑ AM ❑ PM

_____

Treating Doctor(s):_____

Diagnosis/Prognosis:_____

_____

Full description of your symptoms and complications suffered:

_____

_____

_____

Were you hospitalised as an in-patient for this medical treatment? If so, please provide:

Date admitted: ____/____/_____ Date discharged: ____/____/_____

Time admitted: ____:____ ❑ AM ❑ PM Time discharged: ____:____ ❑ AM ❑ PM

Did you return home early? ❑ Yes ❑ No

If yes, please provide the date on which you returned. ____/____/_____

Did you incur travel & related expenses to treat the condition? ❑ Yes ❑ No

If yes, please provide details of these with supporting documentation.

Details of Medical Expenses Being Claimed

Date of Expense	Details of Expense	Amount Claimed	Receipt attached?	Paid / Unpaid?	OFFICE USE ONLY

Details of Travel and Related Expenses Being Claimed

Date of Expense	Details of Expense	Amount Claimed	Receipt attached?	Paid / Unpaid?	OFFICE USE ONLY

Guidance Notes

The following documentation is requested for your claim to be processed.

Item	***Enclosed***
A copy of your travel itinerary detailing your outward and return travel dates	☐
Receipts/Invoices for expenses being claimed	☐
Hospital/Doctor reports/records related to your injury/claim	☐
Copy of your admittance and discharge report from the hospital where your approved medical or dental treatment was performed.	☐
If you returned home early: Confirmation from the treating Doctor of the medical necessity to return early, or if the return was as a result of an illness/death of a relative we require the medical certificate attached to be completed by the usual Doctor of the person causing curtailment.	☐
If you have submitted a claim to another insurance company or third party: Copies of all correspondence	☐

Examples of additional documents that could be required. Including, but not limited to:

- Details of your consultations and/or treatment following any complications, to include the name of the medical facilities and dates.
- If your situation requires travel, please provide explanation as to why treatment is not being provided where you are presently located.
- In some cases, 2nd opinion should be sought, and a relevant medical report of the outcome provided to us for consideration.
- Any details of any other insurance you have in place including public or private coverage, European Health Insurance, credit card benefits, tour operator coverage, other travel insurance, etc.

Additional Comments:

Payment of Claims

Should your claim be accepted for payment we will credit your nominated bank account, please provide the following details:

Name of Bank:…….

Branch Address:……..

Account Number:…….

Name of Account Beneficiary:……..

Account Beneficiary Address (residential address registered with the bank):
……..……..

…….

IBAN:……

SWIFT:……

Currency of Account:……..

Declaration

I declare that to the best of my knowledge all particulars contained in this form are true and correct. In the event of a third party being liable for loss/damage all rights in this matter are subrogated to Optimum Global Insurance Company on settlement of the claim. If cover exists under any other policy, I give my authority for contribution to be sought from their insurers.

Signed: _____ Date: ____/____/_____

Please refer to the Optimum Global Insurance Company Privacy Policy: https://optimumglobal.com/privacy-policy/
and Custom Assurance Placements, Ltd. Privacy policy: https://www.customassurance.com/privacy

Your privacy is important to us. To resolve your claim properly and efficiently, we may need to consult with the program administrator, Custom Assurance Placements; your medical travel facilitator or medical provider; or other insurance, underwriting or reinsurance persons involved in the program. Please sign below to agree to allow medical information or other required information to be obtained for claims handling purposes.

Signed: _____ Date: ____/____/_____