MetLife Europe d.a.c
(Cyprus Branch) 38, Kennedy
Ave., 1087 Nicosia

Tel.: +357 22845845
E-mail: claimscyprus@metlife.com
Website: www.metlife.com.cy

Claim Number:

GROUP INSURANCE CLAIM FORM

Please send your fully completed Claim Form(s) with invoices/receipts by post to: Claims Department

Part A Patient's details

1. First name:
**as submitted at enrollment.*
2. Surname:
3. Identity/ Passport*:
4. Date of birth: D D M M Y Y
5. Gender: ☐ Male ☐ Female

Part B Main Insured details

1. Policy Number:
2. Company Name:
3. First name:
4. Date of birth: D D M M Y Y
5. Gender: ☐ Male ☐ Female
6. Surname:
7. Address:
8. Identity/ Passport*:
**as submitted at enrollment. If it has changed please submit new documentation.*
9. Telephone number:
10. Email:

Part C Claim Description by patient

Description of Illness/ Accident:

When did the first syptopms occured?

Has the patient ever suffered from the same or similar illness before? ☐ Yes ☐ No

If yes, when?:

Name of Doctor(s) that were consulted: Date: D D M M Y Y

Date: D D M M Y Y

Date: D D M M Y Y

GHS (Γ.Ε.Σ.Υ) Visit Description:

Please submit documentation provided by GHS (Γ.Ε.Σ.Υ)

Part D Claim Details

Please complete all parts of the following table with the details of each invoice/receipt. If your invoice/receipt does not include the diagnosis/medical condition, please ensure that you provide us with this information below. If there is insufficient space in the table below, please provide details on a separate page.

Description of expense/treatment	Diagnosis/medical condition	Clinic/Hospital name	Amount charged/ currency	Has this bill been paid by you?
Doctor visit:				Yes ☐ No ☐
Medicine:				Yes ☐ No ☐
Physiotherapies:				Yes ☐ No ☐
Laboratory Tests, x-rays:				Yes ☐ No ☐
Accommodation No of days:				Yes ☐ No ☐
Surgical operations not requiring hospitalization:				Yes ☐ No ☐
Surgeon Fees:				Yes ☐ No ☐
Anesthesiologist:				Yes ☐ No ☐
Natural birth:				Yes ☐ No ☐
Caesarean:				Yes ☐ No ☐
Miscarriage:				Yes ☐ No ☐
Other:				Yes ☐ No ☐
Other:				Yes ☐ No ☐
Other:				Yes ☐ No ☐
Other:				Yes ☐ No ☐
Other:				Yes ☐ No ☐
Other:				Yes ☐ No ☐
		TOTAL	0	

Please submit all supportive documentation for the above expenses

MetLife Europe d.a.c
(Cyprus Branch) 38, Kennedy
Ave., 1087 Nicosia

Tel.: +357 22845845
E-mail: claimscyprus@metlife.com
Website: www.metlife.com.cy

Part E Medical Physician's report

Name of doctor/specialist:

Name of hospital/clinic:

Doctor's Work Tel:

Email:

Applicable to physiotherapy claims only.

Please provide full referral details:

Name of referring physician:

Date of referral: D D M M Y Y

Indicate type of condition: ☐ Acute ☐ Chronic

Please provide full details of the symptoms/medical condition:

On what date did the patient first present these symptoms to you? D D M M Y Y

On what date would the first onset of symptoms have been apparent to the patient? D D M M Y Y

Please provide details of previous visits related to same condition (if any):

If further treatment was recommended/performed:

Detailed description of surgery:

Date of admission: D D M M Y Y

Discharge date: D D M M Y Y

Admission Diagnosis:

Please sign and authenticate with an official stamp.

OFFICIAL STAMP OF MEDICAL PROVIDER

.....

Doctor's signature and stamp

Date D D M M Y Y

Part F Data Protection and release of medical records and Authorisation

Note: If this consent relates to a minor, this form must be completed by the parent or other person with parental responsibility over the child. References to "your health data", "my health data" or similar references must be read as references to the minor's health data.

We, MetLife Europe d.a.c. (Cyprus Branch) of 38 Kennedy Avenue, 1087 Nicosia, use your personal data as further explained below and will be the controller of the personal data you provide to us or that we collect about you.

We request your consent to process your personal data for the purposes detailed below:

1. In order to enable us to process your claim, we will need to process the health data that you have provided or may be asked to provide in the future, including health data that you have provided in the past in respect of this policy or other policies where these are relevant. This may include the need for us to share your health data with doctors or other specialist consultants or legal or other advisors to assist us in or for the purpose of processing your claim.
If you don't provide your consent, we will be unable to process your claim and it will be rejected.
If you agree to this, please tick the box

   ☐ Yes, I agree to MetLife Europe d.a.c. (Cyprus Branch) processing my health data for the reasons referred to above.

2. Sometimes, we may need to check the health data that we have about you with your doctor or other health care professionals or obtain additional health data from them in order to properly process your claim. When this is strictly necessary, we will contact your doctor or other health care providers and ask them to provide us with health data that they have about you.

2. In case you do not provide your consent, we may be unable to process your claim if we consider that it is important for us to check your health data with other sources or obtin additional information from them. In such case, your claim will be rejected. If you agree to this, please tick the box below.

   ☐ Yes, I agree to MetLife Europe d.a.c. (Cyprus Branch) contacting my doctor or other health care providers and asking them to provide it with health data that they have about me for the reasons referred.

3. If your claim is approved and it relates to a health benefit in kind, we may use the services of third parties in providing you such a benefit. In such cases, we will need to share with them the health data that we have about you. If you don't provide your consent, we will be unable to provide you the benefi t in kind if we rely on third parties to do this. If you agree to this, please tick the box below.

   ☐ Yes, I agree to MetLife Europe d.a.c. (Cyprus Branch) processing my health data for the reasons.

You have the right to withdraw this consent at any time by sending us a letter at 38 Kennedy Avenue, 1087, Nicosia or emailing us at ccd@metlife.com. However, in case you withdraw your consent while your claim is still pending, it will be rejected if we consider that it is important for us to check your health data with other sources or obtain additional information from them. This won't affect any previous processing of your data up to that point.

Our privacy policy, which sets out in greater detail how we use your personal data, and your rights in relation to such usage is enclosed and is also available at www.metlife.com.cy.Please confirm that you have read the privacy policy by ticking the box below.

☐ Yes, I confirm that I have read the privacy policy.

I certify and accept that the claim submission is true, and the amounts submitted respond to those listed in the documents I have in my possession. The documents to be submitted are the original ones. The claim is submitted only by the main insured for expenses of the main insured and of the dependent members of this group policy, as they appear in the relevant registration field. The originals of the documents to be submitted by me shall be sent to MetLife within 30 days from the date of submission. In case this is not feasible, it is my responsibility to retain any original supporting documentation where copies are submitted to MetLife, as MetLife reserves the right to request original supporting documentation/receipts up to 6 years after the settlement of the claim. Should an incorrect submission of information occur or in case the original documents are not sent to MetLife, then MetLife has the right to demand the repayment of the amount paid for the specific claim, which regards the specific cause. In case I do not repay the requested amount, MetLife may withhold the whole requested amount or part of it from future compensation related to me or any dependent member of mine, as per what is previously stated. The terms of the group insurance policy, as applicable, shall prevail over the terms of use of this submission. I also acknowledge that in case of deviation of the amount of compensation calculated from the submission by calculation from the General and Special Conditions of the group insurance policy, always prevail last.

Date:

Claimant's signature

Claimant's name