

## Claims Procedures

**PRE-AUTHORISATION IS REQUIRED FROM THE ASSISTANCE COMPANY MOS MEDICAL HELPLINE FOR ALL IN-PATIENT CLAIMS, ANY CLAIM LIKELY TO EXCEED £2,500/\$4,250/€3,250 AND ALL EMERGENCY MEDICAL EVALUATION CLAIMS. FAILURE TO OBTAIN PRE-AUTHORISATION MAY INVALIDATE YOUR CLAIM. FOR FURTHER DETAILS PLEASE SEE YOUR POLICY TERMS AND CONDITIONS.**

Should you require any advice regarding making a claim, or if you are unsure if pre-authorisation is required, please contact our claims team on **+49 (0)69 9778899-999** or email **crewmedical@mosmedical.de**

### There are three types of claims

#### 1. Outpatient claims

- Always take a claim form with you when visiting a doctor/dentist/hospital. You should always complete Sections A and B. The treating doctor/dentist must complete and sign Section C or D. **Please ensure that all questions, in all Sections, are answered fully. Ticks and dashes will not be acceptable and will delay settlement of your claim.**
- A separate claim form must be completed for each ailment or dental treatment.
- The claim form and receipts must be submitted **within 90 days of start of treatment**. If receipts are unavailable

within 90 days, the completed claim form must be still be submitted and original receipts can be sent at a later date. **However, reimbursement in any case is only payable on original receipts.**

- The claim form and original medical bills/receipts must be sent to:  
inTrust Germany  
Cunningham Lindsey Zorn GmbH  
Wilhelmstrasse 96  
42489 Wuelfrath  
Germany

#### 2. Inpatient claims or claims likely to exceed £2,500/\$4,250/€3,250

Before being admitted as an in-patient in hospital, or where it is considered likely that treatment costs will exceed £2,500/\$4,250/€3,250, pre-authorisation must be obtained from the Assistance Company MOS Medical Helpline. In a medical emergency the Assistance Company should be notified within 72 hours of commencement of treatment. Simply ask the Hospital to contact the 24 Hour Assistance Company who can confirm cover, give approval for treatment

costs and make arrangements for direct settlement of bills with the hospital.

**FAILURE TO CONTACT THE ASSISTANCE COMPANY PRIOR TO INCURRING COSTS WILL RESULT IN THE INSURED PERSON BEING RESPONSIBLE FOR £1,000/\$1,700/€1,300 OF EACH CLAIM**

Telephone: **+49 (0) 69 9778899-999**  
E-mail: **crewmedical@mosmedical.de**

#### 3. Emergency medical evacuation claims

If urgent medical treatment is required which is not available locally the Plan usually provides cover for Emergency Medical Evacuation.

- Prior to making any travel arrangements**, approval must be obtained from the Assistance Company MOS Medical Helpline. In the first instance telephone the following number:

Telephone: **+49 (0) 69 9778899-999**  
E-mail: **crewmedical@mosmedical.de**

This number is available 24 hours a day, 365 days a year. They will need to know the answers to the following questions - please have your replies ready before

telephoning for assistance:

1. Patients full name, date of birth, nationality and current address
2. Certificate Number or Group no.
3. Medical Problem/Situation/Assistance requested
4. Date of occurrence of illness/accident
5. Hospital name and telephone number
6. Treating Doctor's name and telephone number
7. Name of Patient's own physician, if any

- The Assistance Company will advise the action to be taken, and make the necessary arrangements for air tickets to be purchased, if necessary. They will also make arrangements for Hospital admissions upon arrival at the approved destination.

**Claim Form**

**PLEASE COMPLETE IN BLOCK CAPITALS AND TICK RELEVANT BOXES. FAILURE TO COMPLETE THE FORM FULLY WILL DELAY SETTLEMENT OF YOUR CLAIM. PLEASE ENSURE YOU HAVE READ THE CLAIMS PROCEDURES PRIOR TO MAKING A CLAIM**

**How to make a claim**

Written notification of claims must be provided within 90 days of the initial consultation, even where original invoices are not yet available. To help us deal with your claim promptly, please:

1. Complete a separate claim form for each illness/accident/dental treatment/maternity or wellness benefit claim and each Insured Person
2. Ensure that the doctor or dentist who treats you fully completes the sections overleaf
3. ALL questions must be answered in full (ticks or dashes will not be acceptable)
4. ALL routine dental treatment must be supported with confirmation of an annual check up.
5. When calculating claims, the exchange rate at time of adjudication is used.
6. Original accounts for treatment received must be

submitted.

7. **Important:** all inpatient claims and any other **claim likely to exceed £2,500 /\$4,250/€3,250** from the outset must be pre-authorized by the Assistance Company. Failure to do so will result in the **insured person being responsible for £1,000/\$1,700/€1,300** of treatment costs.

**Please complete and return to:**

inTrust Germany  
Cunningham Lindsey Zorn GmbH  
Wilhelmstrasse 96  
42489 Wuelfrath  
Germany

**Section A – Patient Information**

**TO BE COMPLETED BY THE INSURED PERSON OR HIS/HER LEGAL REPRESENTATIVE**

1. Full name:

Title:            Mr            Mrs            Miss            Ms            Other:

Surname:

Postcode:

Forenames:

Country of residence:

2. Date of birth:

Telephone:

3. Certificate number:

Facsimile:

4. Sex:

Male            Female

Email:

**Section B – Claim Information**

**TO BE COMPLETED BY THE INSURED PERSON OR HIS/HER LEGAL REPRESENTATIVE**

6. State the nature of illness and the date upon which symptoms first occurred:

9. If the cause of the illness relates to an accident, state the date of the accident and give brief details of the circumstances and injuries received:

7. Have you ever received treatment (including prescription drugs) for this condition or any related condition before this episode. Please provide dates and details of previous treatment.

10. Do you have any other insurance that provides cover for healthcare benefits?

8. How long have you had these symptoms before consulting your doctor?



11. Date of Treatment	List Expenses for Which Reimbursement Claimed (Original accounts will be required)	State Currency and Amount Paid	State in Full, to Whom you Wish Settlement Paid

12. Are further accounts to be submitted? If so please give details:

13. Is this a continuation of previous or current treatment for which you have already claimed under this policy? If yes, please give details, including claim reference number:

14. Please provide the name and address of your usual General Physician:

Postcode:

Country of residence:

Telephone:

Facsimile:

Email:

15. Please provide details of other doctors and or surgeons who have treated you for this or related conditions

16. I authorize –revocable at any time- (1) TMK and third parties commissioned by them (such as inTrust and MOS) to collect, process and use my personal data as well as the

release of any medical information necessary to process this claim and (2) the processing of any medical information or other personal data provided by me or by my physician/dentist and the disclosure of such information to underwriters via claims handling agents as well as the medical assistance provider and, where relevant to loss adjusters for the purpose of this claim. **Unless you give consent to this authorization, we are not able to process your claim.** I declare that I have not received medical advice or treatment or experienced symptoms for the illness/injury for which I am now claiming within two years prior to the first date of my insurance cover under this policy. (This does not apply if you are insured under a Group Plan where the Pre-Existing Condition exclusion has been waived). To the best of my knowledge all the afore mentioned particulars are true.

I consent – revocable at any time- that my health data and other personal data may be transferred to the responsible Pantaenius office and that it may be processed and utilized there in order to evaluate my entitlement or to be forwarded to other responsible insurers for claiming my entitlement. Where required, I release all persons employed by TMK, inTrust and MOS from their obligations of confidentiality in regards to my health data and any other personal data that is protected by law.

Signature of Insured Person or Legal Representative:

Date



Third Party  
Administration

arrange for handling of your claim to be managed by insurers themselves.



TOKIO MARINE  
KILN

### Section C – Medical Information

#### TO BE COMPLETED BY THE TREATING PHYSICIAN

17. Please state the date on which the patient first consulted you for this or any similar or related condition:

22. Please give a history of this or any related or similar conditions with dates on which any previous treatment or investigation took place:

18. Please describe the symptoms presented and state when symptoms first occurred:

19. Please give name and address of the referring Physician:

Postcode:

Country of residence:

Telephone:

Facsimile:

Email:

23. If all or a part of the treatment was in respect of elective cosmetic surgery, please indicate the amount or the proportion of the costs involved:

24. Have you any reason to believe that the treatment for the same or similar condition has been given previously? If yes, give details:

20. Please give your diagnosis of the illness/injury:

25. In respect of claims for maternity care please state the expected delivery date and the date on which the patient first consulted you for this pregnancy:

21. Is the condition likely to be considered congenital or a birth defect? If so please provide details:

Signature of treating physician:

Please state your qualifications:



**Section D – Routine Dental Treatment Information**

**TO BE COMPLETED BY THE TREATING DENTIST**

a. Has the patient attended for routine check-up in the past 12 months and was all necessary treatment concluded?

b. In your opinion has the patient maintained good dental hygiene?

c. Please describe dental necessity for this claim?

d. Please print your name and address:

Postcode:

Country of residence:

Telephone:

Facsimile:

Email:

Signature of treating dentist:

Please state your qualifications:



**CLAIMS SETTLEMENTS BY BANK TRANSFER  
BANK DETAILS FORM**

Please complete this form and return it to inTrust Germany, Cunningham Lindsey Zorn GmbH:

inTrust Germany  
Cunningham Lindsey Zorn GmbH  
Wilhemstrasse 96  
42489 Wuelfrath  
GERMANY  
Tel: +49 (0) 2058 9230 52  
Fax: + 49 (0) 2058 9230 30  
Email: crewmedical@cl-int.com

**Please note that our bank requires the BANK SWIFT number and the BANK IBAN number for ALL International Bank Transfer of Funds.**

POLICY NUMBER:

BANK NAME:

BANK ADDRESS:

ACCOUNT HOLDER:

ACCOUNT HOLDER ADDRESS:

ACCOUNT NUMBER:

BANK SORT CODE (UK only) :

SWIFT NUMBER:

IBAN NUMBER:

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## Consent to ascertain and use health data and Confidentiality waiver declaration

**Policy no./Certificate no.** \_\_\_\_\_  
**Claim no.** \_\_\_\_\_  
**Date of loss** \_\_\_\_\_  
**Name of insured person** \_\_\_\_\_

### Consent to ascertain and use health data and Confidentiality waiver declaration

(The text of the declaration of consent/ confidentiality waiver is based on the sample consent and confidentiality waiver clause for life and health insurance agreed with the data protection agencies.)

#### 1. Asking for health data from third parties

##### 1.1 Asking for health data from third parties in order to check insurer's obligation to provide benefits

In order to check the payment obligation in regards to your insurance case it may be necessary that Tokio Marine Kiln Europe S.A., authorised by Lloyd's insurer London, Syndikat 510, German branch, hereafter referred to as TMK, may need to check the details of your health circumstances, which you stated in support of your claim, or which are featured in the documents submitted (for example bills, orders and evaluations) or notes from, for example, a doctor or other care professionals.

This check is only carried out where necessary. For this, TMK requires your consent, including a confidentiality waiver declaration for the company, as well as for any authorities to which information may have to be forwarded in the context of checking the health data or other personal data and information protected by law.

You may issue this declaration now (I) or at a later point in individual cases (II) and you may change your decision at any point. Please choose one of the following options:

**Option I:**

I consent, revocable at any time, that TMK – as far as is necessary for checking my claim – may acquire my health data from doctors, care professionals as well as hospital employees, other care institutions, care homes, personal insurers, state health insurance providers, employer mutual insurance associations and authorities and to use it for this purpose.

I am releasing the above mentioned persons and employees of the named organisations from their obligation of confidentiality, as long as the data on my health in regards to check-ups, consultations, treatments, as well as insurance applications and contracts covering a period of up to ten years before submitting the application is stored in a safe manner and transferred to TMK or their Third Party Administrators (TPAs).

I furthermore agree, revocable at any time, that my health data can be forwarded to these authorities in this context – where necessary – and am therefore also releasing persons employed or authorised by TMK from their obligation of confidentiality.

I will be notified, by whom and for what purpose data will be requested, before making such data requests in accordance with the above-mentioned paragraphs, and it will be explained to me that I may appeal against this and submit the required documents myself.

**Option II:**

I would like TMK and their TPAs to notify me in each individual case, from which persons or organisations data will be required for this purpose. I will then decide respectively, whether I

- will consent to the request and utilisation of my health data by TMK or their TPAs, the release of the named persons or organisations, as well as their employees, from their obligation of confidentiality and the transfer of my health data to TMK or their TPAs
- will supply the required documents myself.

I am aware that this may lead to a delay in regards to checking the payment obligation.

For as long as the above declarations apply to my application statements, they will be valid for a period of five years after finalising the contract. Should TMK or their TPAs become aware of concrete evidence after finalising the contract, that the application intentionally contains false or incomplete data, and that the risk evaluation was therefore affected, the declarations will be valid for ten years after finalising the contract.

### 1.2 Declarations in the case of your death

It may be necessary to check health statements even after your death, in order to check a payment obligation. We will also need your consent and a confidentiality waiver declaration for this.

#### Declaration in the case of my death:

I agree, revocable at any time, to the request of health data from third parties in the case of my death as described in the first tick-box (see above 1.1 – option I), in order to check insurer's obligations to provide benefits.

## 2. Forwarding health data and other personal data or information protected by law to organisations other than TMK

TMK obliges the following organisations by contract to adhere to the data protection and data safety regulations.

### 2.1 Forwarding data for medical evaluations

In order to check the payment obligation, it may be necessary to involve a medical expert. TMK and their TPAs require your consent and a confidentiality waiver declaration, should your health data and other personal data protected by law be forwarded in this context. You will be notified of the respective data transfer.

- I consent, revocable at any time, that TMK may forward my health data to medical experts, should this be required in regards to checking the payment obligation and to use my health data for this purpose accordingly and to forward the results back to TMK or their TPAs. I waive the confidentiality requirement for persons and evaluators employed or authorised by TMK in regards to my health data and other personal data protected by law.

### 2.2 Transferring tasks to other parties (companies or persons)

TMK do not carry out some of the tasks themselves, such as the organising of assistance services, where your health data may be acquired, processed or used, but transfer the task to a third party. Should your personal data, which is protected by law, be passed on, TMK will require your confidentiality waiver declaration for itself and, if required, for other parties.

TMK maintains a continuously updated list of third parties and third party categories, who acquire, process and use the health data for TMK as agreed, whilst stating the transferred task. The current list has been attached to the consent declaration. TMK will require your consent in order to forward your health data and for the third parties named in the list to use the data.

- I consent, revocable at any time, that TMK may transfer my health data to the above-mentioned list and that the health data will be acquired, processed and utilised by them for the agreed purpose and to the same extent as has been granted to TMK. As far as is necessary, I am releasing TMK's employees and other third parties from their confidentiality obligation in regards to forwarding health data and other personal data protected by law.

### 2.3 Forwarding data to reinsurances

In order to ensure that claims are being met, TMK may utilise reinsurances, which take over all or some of the risk. In some cases reinsurances may also work with other reinsurances, to whom they may transfer your data. So that the reinsurances may look at the insurance case independently, it is possible that TMK may present your payment application to the reinsurance. This is especially the case, if the insurance amount is exceptionally high, or if it concerns a risk that is difficult to evaluate.

Furthermore it is possible that the reinsurance may support TMK because of their specialist knowledge in regards to risk and payment checks, as well as in regards to evaluating the processes.

If reinsurances have taken on the risk, they may check, whether TMK has evaluated a risk or payment case correctly. Furthermore data in regards to your existing contracts and applications may be forwarded to the reinsurances to the necessary extent, so that they may check, whether and to what extent they may take a share in the risk. In regards to premium payments and payment cases, your data in regards to existing contracts with reinsurances may be forwarded.

In regards to the above-mentioned purposes, data will mostly be anonymised or pseudomised, but personal health details may also be used. Your personal data will only be used by the reinsurances for the above-mentioned purpose. You will be notified in regards to the transfer of your health data to reinsurances.

- I consent, revocable at any time, that my health data – where necessary – may be forwarded to reinsurances and used by them for the above-mentioned purpose. Where necessary, I release all persons employed or authorised by TMK in regards to their confidentiality obligation concerning the health data and all other personal data protected by law.

### 2.4 Data exchange with the notification and information system (HIS)

The insurance industry uses the notification and information system HIS in regards to detailed payment evaluations, which is currently operated by informa Insurance Risk and Fraud Prevention GmbH (informa IRFP GmbH, Rheinstraße 99, 76532 Baden-Baden, [www.informa-irfp.de](http://www.informa-irfp.de)). Peculiarities, which may indicate an insurance fraud, and heightened risks may be notified to HIS by TMK. TMK and other insurance organisations check on data stored in HIS in the context of the payment evaluation, should a justified interest exist. Even though health data will not be forwarded in this respect, TMK will require a confidentiality waiver declaration from you in regards to forwarding your data that is protected in accordance with the valid data protection and data security laws. This applies irrespective of whether a contract has been finalised with you or not.

- I release, revocable at any time, all persons employed or authorised by TMK from their obligation of confidentiality, in regards to when they notify data from payment evaluations to the respective operator of the notification and information system (HIS).

Should it be required for the evaluation of the payment obligation, other insurance organisations may be identified via HIS, with which you may have been in contact in the past and who may hold information that may be useful for the process. Any data required for the continued payment evaluation may be requested from them.



**Declaration of consent in regards to forwarding data and for agent or broker assistance for payment cases (if this is requested)**

Please sign the following declaration of consent, if your insurance contract was organised by an insurance agent or broker and if you would like to use their services in regards to the above-mentioned payment case.

- I consent, revocable at any time, that my health data may be transferred to the insurance agent or broker mentioned in the insurance contract at the time of validating the payment claim and that it may be processed and utilised in order to evaluate my entitlement. Where required, I will release all persons employed or authorised by TMK from their obligation of confidentiality in regards to the health data and any other personal data that is protected by law.

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Place, date

Signature of insured person (if capacity of discernment has been guaranteed, but upon completion of 16 years of age the earliest)

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Place, date

Signature of the legal representative of insured person

**Overview on the categories and the main service providers authorised by the German branch of Tokio Marine Kiln Europe S.A., in accordance with paragraph 1.2 or 2.2 of the declaration of consent and the confidentiality waiver declaration**

Category	Company description	Activities
<b>General service provisions</b>	Waste disposal companies	Professional disposal of data storage devices and paper documents in accordance with data protection
	Printing companies and printing confectioners	Printing and compiling insurance documents
	IT providers	Establishing and maintaining IT systems, application development, internet administration
	Re-insurers	Re-insurance of certain risks
	Law firms	Representing our interests, for example in the case of claims
<b>Insurance-specific services</b>	Cunningham Lindsey Zorn GmbH, business unit inTrust Germany	Claims handling in regard to travel insurance
	MOS medical helpline GmbH, Murnau	Medical assistance services
	GMMI Global Medical Management, Florida, USA	Case Management and Cost Containment in regard to travel insurance

Your health data and all other personal data that is protected by law will be stored in TMK's IT systems. Data that is protected by law refers also to „external secrets, namely secrets in regards to personal circumstances or company or business secrets.“ In regards to insurances, this refers especially to the information that an insurance contract exists. Your health data may only be accessed by a limited amount of persons within Tokio Marine Kiln Europe S.A. authorised by Lloyd's insurers London, Syndicate 510, the German branch. Any of your other personal data (for example start of the insurance, your address) may also be viewed by other TMK employees, for example when processing contracts. It is theoretically possible, that your data might be viewed by a small number of employees of the Tokio Marine Kiln Group or by Lloyd's insurers, London. **Tokio Marine Kiln Group Limited** is a British company with headquarters in **London, UK** (you are welcome to view more details at [www.tokiomarinekilngroup.com](http://www.tokiomarinekilngroup.com)).

This list does not include your insurance agent or persons authorised by them. Please contact them directly should you have any questions in regard to forwarding of data, which have been requested by your insurance agent. Health data, which might be requested by us in case of a payment (and with your consent) will only be forwarded to your insurance agent, if you have given explicit consent (in case claims are submitted).

**Separate notification in regards to the consequences of a breach of duty after the occurrence of an insurance case (see § 28 par. 4 insurance contract law)**

Dear client,

We rely on your co-operation in regards to the occurrence of an insurance case.

**Disclosure and explanation duties, provision of proof:** Due to the contractual agreements you have entered into, we may request that you disclose information to use in a truthful and timely manner after the occurrence of an insurance case, as this may be required in regards to the determination of an insurance case or to calculate the degree of our payment duty, and that you enable us to check on our payment duty in that you will undertake everything in your power in order to assist the finding of facts. We may also request that you present timely proof to us, as long as this is reasonable.

**Payment exemption:** If you intentionally breach your duty to provide information, explanations or proof, you will lose your entitlement to any insurance payments. If you breach your duties due to gross negligence, we may reduce your payment in proportion to the gravity of your blame – if necessary until you lose all of your entitlements. A reduction will not be applied, if you can proof that the breach of duty was not due to gross negligence.

Even if you breach your duty to provide information, explanations or proof, we will be obliged to provide services to you if you can prove that the intentional or grossly negligent breach of duty did not have an effect on the establishment of the insurance case or the extent of our payment duty.

If you breach your duty to inform, explain or provide proof fraudulently, we will be exempt from our duties in any case.

**Note:** If the rights for the contractual service do not apply to you, but to a third party instead, this person will also be required to inform, explain and present proof.