PANTAENIUS Yacht Insurance

inTrust Third Party Administration

TOKIO MARINE KILN

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

a. 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.**

b. A separate claim form must be completed for each ailment or dental treatment.

c. 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**.

d. 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.

a. **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

b. 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.

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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-authorised 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:

   Forenames:

2. Date of birth:

3. Certificate number:

4. Sex: Male Female

5. Full mailing address of claimant:

   Postcode:

   Country of residence:

   Telephone:

   Facsimile:

   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:

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.

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

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:

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

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	Currency of Settlement

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 or other doctors and or surgeons who have treated you for this or related conditions

16. I authorise (1) 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 and, where relevant to loss adjusters for the purpose of this 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 content that my health data may be transferred to the insurance broker Pantaenius and that it may be processed and utilized there in order to evaluate my entitlement or to be forwarded to other 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 data that is protected in accordance with §203 of the German penal code.

Signature of Insured Person or Legal Representative:

Date

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:

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:

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

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

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

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:

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:

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:

Please note that inTrust Germany, Cunningham Lindsey Zorn GmbH, has authority from your insurers to handle claims on their behalf subject to certain limitations. If you do not wish us to act on this claim as agent of both yourself and insurers, you should advise us by return and we will arrange for handling of your claim to be managed by insurers themselves.

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: