Out-patient Claim Form

laya healthcare
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Using this claim form

Claims should be sent to: **Laya healthcare**, PO Box 12679, Dublin 15.

Guidelines to making your claim for out-patient expenses

- The Revenue Commissioners will now accept your Statement of Claim (which we will send to you when your claim has been assessed) as evidence of medical expenses incurred
- Claims must be submitted within twelve months from the end of your policy year
- Claims should be made at renewal date
- If your scheme has an annual excess, this excess will be applied to your claim. The amount of the excess deducted will depend on your scheme
- If you have not already provided your bank account details for your claims to be paid directly into your account, please complete Section 2 which requires the policyholder's signature.

Important note

For a full list of the out-patient benefits available on your scheme please log in to the "Member Area" in our website, **www.layahealthcare.ie** or contact us on **021 202 2000.**

1 Member's details

Membership no: ☐☐☐☐☐☐☐☐☐☐

Title:	Surname:	Forenames:
Date of birth: Day ☐☐ Month ☐☐ Year ☐☐		Phone (mobile preferred):
Correspondence address:		
Email:		

2 Your claims payment details

To ensure prompt payment of your claim, we can arrange to make payment directly, where possible, into your bank account. If you currently pay your subscriptions by Direct Debit and would like to have your claims paid, where possible, directly to this account please tick the box. ☐
If you have already provided your bank account details for your claims to be paid directly into your account, you do not need to resubmit this information.
Alternatively please complete the mandate with your bank account details. If you do not provide these details or if you provide us with incorrect bank details we will pay you by cheque.

Name(s) of account holder(s):

IBAN: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

BIC: ☐☐☐☐☐☐☐☐☐☐☐

Please write the full name and address of your bank or building society.

Policyholder's signature(s):

Date: Day ☐☐ Month ☐☐ Year ☐☐

I/we will inform **laya healthcare** if I/we wish to cancel the existing instruction for future claims payment.

3 Declaration

I declare that the expenses detailed on this form were incurred by me and/or my dependants covered under my membership in respect of services received during the subscription year, on the recommendation of registered medical practitioners. I declare that, to the best of my knowledge, the foregoing statements are true in every respect. For the purpose of considering and determining the eligibility/appropriateness of claims **laya healthcare** may request the hospital/specialist/consultant/physician/health provider concerned to furnish **laya healthcare** or its duly authorised agents acting on its behalf (including, but not limited to, medical professionals whose services are retained by **laya healthcare**) with all necessary information as **laya healthcare** or its authorised agents may seek in connection with any treatment or other services provided to you or your dependant(s). I direct and authorise that all medical expenses (paid out by **laya healthcare**) recovered from the third party responsible for my/the patient's injuries shall be refunded by my solicitor directly to **laya healthcare**. I further direct my solicitor to deduct these amounts from my settlement cheque and reimburse **laya healthcare** directly. In the event that medical expenses recovered from the third party are refunded directly to me, the member, I agree to refund these monies directly to **laya healthcare**.

✗ **Policyholder's signature**
(a parent or guardian if patient is under 16)

Date:

Note: Payment and Explanation of Benefits will be issued to the policyholder.

Data Privacy Statement

"**Personal Information**" identifies and relates to you or other individuals (e.g. your partner or other members of your family). If you provide Personal Information about another individual, you must (unless we agree otherwise) inform the individual about the content of this notice and our Privacy Policy and obtain their permission (where possible) to share their Personal Information with us. Depending on our relationship with you, Personal Information collected may include: contact information, financial information and account details, sensitive information about health or medical conditions (collected with your consent where required by applicable law) or (where we require it and are legally permitted to collect it). Personal Information may be used for the following purposes:

- Insurance administration, e.g. communications, claims processing and payment
- Assessments and decisions about the provision and terms of insurance and the settlement of claims including but not limited to: a) analyse, examine or clinically audit the care, claims processes and treatment/ overnight-stay/ convalescence /care pathway options applied/utilised by medical service providers; b) to undertake investigations into, and to adjudicate on, patient's claim (including investigations into the length of the patient's hospital stay and the treatment received whilst in hospital)
- Assistance and advice on medical and travel matters
- Management of our business operations and IT infrastructure
- Prevention, detection and investigation of crime, e.g. fraud and money laundering
- Establishment and defence of legal rights
- Legal and regulatory compliance (including compliance with laws and regulations outside your country of residence)
- Monitoring and recording of telephone calls for quality, training and security purposes
- Audit of medical service providers and the handling of claims by a medical services provider
- Marketing, market research and analysis

For the above purposes, Personal Information may be shared with our group companies and third parties (such as insurance distribution parties, healthcare professionals and other service providers). Personal Information will be shared with other third parties (including government authorities) if required by laws or regulations. Appropriate technical and physical security measures are used to keep your Personal Information safe and secure.

When we provide Personal Information to a third party (including our service providers) or engage a third party to collect Personal Information on our behalf, the third party will be selected carefully and required to use appropriate security measures. You have a number of rights under data protection law in connection with our use of your Personal Information. These rights may only apply in certain circumstances and are subject to certain exemptions. These rights may include a right to access Personal Information, a right to request that we correct inaccurate data, erase data, or suspend our use of data. These rights may also include a right to transfer your data to another organisation, a right to object to our use of your Personal Information, a right to request that certain automated decisions we make have human involvement, a right to withdraw consent and a right to complain to the data protection regulator in your country. Further information about your rights and how you may exercise them is set out in full in our Privacy Policy (see below). More details about your rights and how we collect, use and disclose your Personal Information can be found in our full Privacy Policy which is available at https://www.layahealthcare.ie/privacypolicy or upon request by writing to Privacy Lead, LayaHealthcare, Eastgate Road, Eastgate Business Park, Little Island, Co Cork, T45 E181 or by emailing info@layahealthcare.ie

4 Receipt details

Treatment type:	Number of receipts:	Total cost of receipts:	Treatment type:	Number of receipts:	Total cost of receipts:
1			6		
2			7		
3			8		
4			9		
5			10		

5 Accidents section (please complete in all cases involving injury)

Description and date of accident/injury: Day ☐☐ Month ☐☐ Year ☐☐

Are the expenses recoverable from another source? Yes ☐ No ☐

If yes, are you claiming these expenses through: Solicitor: Yes ☐ No ☐ or Personal Injuries Assessment Board: Yes ☐ No ☐

If either of the above are selected, please state the name, address and policy details:

I declare that **laya healthcare** may contact my solicitor in order to ensure that any monies payable from a third party, as a result of an accident or an injury, are repayable to **laya healthcare** to offset against any claims we pay:

Signed (insured member if over 16) Signed (subscriber)

6 Emergency dental section

Date and place of injury: Day ☐☐ Month ☐☐ Year ☐☐

Description of accident/injury:

To be completed by dentist providing treatment	Date:	Description of work carried out:	Cost:
Date treatment commenced:			
Treatment dates:			
Date treatment completed:			

Signature and stamp of dentist

Checklist:

Please ensure the following are completed so we can assess your claim

Please Tick ✓

- Did the main policyholder* sign the claim form? ☐
- Did you input your bank account details so payment can be made quickly, directly into your account? ☐
- Did you supply the original receipts? ☐
- Did you make a copy of your receipts for your own records, as it is the company policy of **laya healthcare** not to return the original receipts? ☐
- Do all your receipts include the name of the patient, the name of the GP, consultant, therapist etc, the cost incurred and the date of the visit? ☐

***The policyholder is the first name listed on the policy. All other members are classed as dependants.**

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