Fiji Care

INSURANCE LIMITED

CLAIM FORM
FOR MEDICAL EVACUATION

"better health for Fiji"

9th Floor, FNPF Place, Victoria Parade, Suva, P O Box 15808, Suva, Fiji.
Phone : (679) 3302 717 Fax : (679) 3302 119
E-mail : fijicare@connect.com.fj

Nadi Office: Level 1, Shop 5, Airport Central Building, Namaka Lane, P O Box 4179, Nadi, Fiji.
Ph: +679 6727348 Fax: +679 6727326 E-mail: nadi@fijicare.com.fj Website: www.fijicare.com.fj

A.	**GUIDE TO COMPLETION OF MEDICAL CLAIM FORM**					
A.	This medical claim form is to be completed and to be accompanied by reports from specialist physicians, surgeons, pathologists, radiologists etc. who have been involved in your care.					
B.	All questions must be answered.					
C.	The completed form will be treated in confidence and will remain the property of FijiCare.					
D.	It must be presented within 31 days of its completion and any fees charged for its completion by a medical practitioner are payable by the claimant.					
E.	The benefits of overseas medical evacuation and treatment must first be recommended and certified by a medical practitioner and also state that the treatment for the disability suffered by an insured **is not** available in Fiji.					
F.	If so certifying, the medical practitioner appointed for the purpose by FijiCare will disregard alternative methods of treatment not available in Fiji, unless the insured holds an executive cover and the disability is covered under that policy.					
G.	The benefits described in the policy will not be claimable unless **prior** approval for such course of treatment has been obtained from FijiCare in accordance with the policy terms and conditions.					
H.	Please refer to your policy document for details of conditions and exclusions and contact FijiCare if need be for clarification. Your employer or Group Insurance representative will have a policy document, or you can ask to see one at FijiCare.					
I.	The claimant may be required to produce his/her: a) birth certificate b) an **at work** certificate c) current pay slips d) passport e) marriage certificate (please arrange to have available)					
J.	Any false statement made on this form may result in your claim being declined.					
B.	**PATIENT INFORMATION** (to be filled by claimant or his/her broker or legal representative)					
1	Surname of claimant					
2	First Name(s)					
3	Sex	Male		Female	*(Circle)*	
4	Date of Birth					
5	Name of Insured Member					
6	Residential Address					
7	Postal Address					
8	Contact Telephone					
9	Fax Number					
10	Country of Citizenship					
11	Passport Number					
12	Do you have residency or citizenship in any other country? If so, please state.					
13	Give details of any other Health Insurance Cover (including National Health of any other country)					
14	Are you applying for any workmen's or other compensation related to this disability?	Yes		No		

15	**Relationship to Insured Member**	self	spouse	defacto	legally separated		
		child	parent	other	*(Circle)*		
C.	**EMPLOYMENT INFORMATION** (to be completed by the claimant, or his/her employer, broker or legal representative)						
16	Present employment and employer						
17	Length of time in employment						
18	Previous occupation in last 5 years						
19	Are you currently on sick leave?						
20	For how long?						
D.	**INSURANCE HISTORY** (to be completed by claimant or his/her broker or legal representative)						
21	Have you personally filled an application form with FjiiCare before today?						
22	Have you had a medical evacuation for this disability already?						
23	Have you had a medical evacuation for any other disability?						
24	If yes, with which Insurance Company?						
25	Date of previous evacuations						
26	Have you ever had a claim denied, deferred or rejected? Give details.						
E.	**CLAIM INFORMATION** (to be completed by the insured person or his/her broker or legal representative)						
27	State nature of illness, date, place, and circumstances under which first symptoms occurred.						
28	If the cause of the illness relates to an accident, give details of accident and injuries received.						
29	Is a Police report available?	Yes		No			
30	If a motor vehicle accident, give details of category of Insurance Cover, Insurance Company and Policy number.						
31	Were you admitted to hospital for this illness? If so state admission and discharge dates.						
	Admission Date		Discharge Date				
32	Have you received treatment for this condition or any associated condition within the last three years?	Yes		No			
33	Or at any time prior to joining FijiCare?	Yes		No			

34	Is this claim for continuation of previous treatment or current treatment for which you have already claimed under this or any previous policy or for which you have paid? (give details).				
35	Are you on medication (give details)?				
36	Are you suffering from or have you ever suffered from or received advice or treatment for (please tick √ yes or no)				
		Yes		No	
	Asthma				
	High Blood Pressure				
	High Cholesterol				
	Heart Condition				
	Asthma, Bronchitis, TB etc				
	Stomach or Intestinal Disorder				
	Brain or Nervous Disorder				
	Kidney Disease Including Colic				
	Cancer				
	Epilepsy or fits of any kind				
	Congenital or Hereditary Disorder				
	Stroke				
	AIDS/AIDS Related Disease				
	Sexually Transmitted Disease				
	Gout, Arthritis				
	Skin Disorder				
	Diabetes				
	Muscle or Skeletal Problem				
	Accident or Work Related Injury or Disability				
	Surgical Operations in last 10 Years				
	Any Other Medical Condition				
F	**HABITS (please tick √ yes or no)**				
		Yes		No	
37	Do you drink alcohol?				
38	Do you smoke?				
39	Are you on any medication not prescribed by a doctor (include vitamins or herbal preparations)				

G	**CLAIMANT'S DECLARATION** (to be filled by the Claimant)	
40	a)	I declare that the details given by me are true and correct in every material respect and I authorise FijiCare to make any necessary checks to confirm such information.
	b)	I undertake to pay the fees for this report.
	c)	I authorise the medical practitioner who completed this certificate to release to FijiCare or the medical practitioner appointed by them for the purpose, information on this form and any other information required.
	d)	I also agree to pay for any further medical examination locally which may be required but on the basis that if the evacuation is approved, I will be reimbursed.
	e)	I agree that if my evacuation is declined and I wish to appeal the decision, I will abide by the arbitration clause in the policy.
	f)	I agree to make myself available for an interview with the medical practitioner appointed by FijiCare for the purpose to assess my application prior to final approvals being given.
	h)	I am prepared to allow release of all necessary medical reports, opinions, and information on me, which would mean an invasion of my privacy, but nonetheless I wish this information to be given to FijiCare for my claim to be processed.
	..... **CLAIMANT'S SIGNATURE**	..... **DATE**
H	**MEDICAL INFORMATION** (to be filled by treating medical practitioner or medical practitioner appointed by FijiCare for the purpose)	
41	Please state the date on which the patient first consulted you	
42	Please state symptoms reported and date on which symptoms first occurred	
43	Please give name and address of the medical practitioner who referred this case to you.	
44	Please give your diagnosis of illness/injury.	
45	Please give a history of this or any related condition of claimant with dates on which any consultations and/or treatment took place.	

46	Please state investigations ordered (attach copies of laboratory reports, X-Rays, ECG, Stress Tests etc).		
47	Please state subsequent follow-up, management and treatment including referrals to specialists.		
48	If patient is to be referred overseas, what is your recommended treatment?		
	1) Investigations recommended		
	2) Surgical management recommended		
	3) Medical management recommended		
I	**SUMMARY** (to be completed by treating medical practitioner or medical practitioner appointed for the purpose by FijiCare)		
49	I recommend evacuation for the following reasons (Please tick, cross, or add answers)		
	i)	No treatment for this disability available in Fiji.	
	ii)	Treatment is available in Fiji but **recommended** treatment is not available (give details).	
	iii)	Treatment is available in Fiji but patient prefers overseas treatment.	
	iv)	Treatment is **not** available in Fiji Government Hospital but is available privately in Fiji.	
	v)	Treatment is available in Fiji Government Hospital and is also available privately in Fiji	
	vi)	All management options in Fiji have been exhausted and further investigations are required.	
	vii)	Continuing treatment is available in Fiji but the opinion of an overseas specialist will improve prognosis (please state the speciality required).	
	viii)	If **urgent**, please give reasons	

50	Have you any reason to believe that treatment for the same condition has been given previously and not disclosed?			
51	Have you any reason to believe that the patient has not fully disclosed details of his/her condition, or given an incorrect date for onset of symptoms?			
52	Does treatment relate to a birth defect, congenital illness or cosmetic surgery?			
J.	**MEDICAL PRACTITIONER'S DECLARATION**			
53	Name			
	Address			
	Telephone Number		Fax Number	
	E-mail			
54	Do you know the applicant other than professionally?			
55	Are you related to him/her?			
56	I certify that : * I have examined the claimant's application and history and I am satisfied that the particulars given to me are correct and accurate.			
57	* symptoms date from the time stated and that the claimant may not have been aware of a pre-existing disability that was symptomatic.			
58	* This form was signed by the claimant in my presence.			
59	* The statements made by me on this form are true to the best of my knowledge and belief. **Signed : ……..** **Date : ……**			