Massy United Insurance Ltd.
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massyunited.com

AZV **Plus** | Claim Form

Name Policyholder / Employer	:	
Name Insured / Patient	:	
Certificate Number	:	
Claim Date	:	

Type of Claim *(Please check the applicable box. You must use another form for a different illness or injury)*

SECTION 1 - Supplemental Health

Vision Care	**Dental Care**	**Outpatient Services**	**Hospital Services**
☐ Eye Examination	☐ Dental Treatment	☐ Physiotherapy	☐ Hospital Confinement
☐ Lenses	☐ Orthodontic Treatment	☐ Chiropractic Therapy	☐ Surgical Expenses
☐ Frames		☐ Second Opinion	☐ Child Birth
☐ Contact Lenses		☐ Other,	

SECTION 2 - Travel Benefits

Outpatient Services	**Hospital Services**	**Additional Coverage**
☐ Prescription Medicines	☐ Hospital Confinement	☐ Dental Treatment
☐ Physician Consultation	☐ Surgical Expenses	☐ Personal Accident
☐ Diagnostic Test	☐ Emergency Room	☐ Medical Evacuation
☐ Local Ambulance	☐ Intensive Care	☐ Repatriation of Remains

SECTION 3 - Accidental Death and Dismemberment

☐ Accidental Death ☐ Permanent Disability / Dismemberment

Claim Details

Please give further details about the claim and services received :

Have you placed a similar claim this year with Massy United? ☐ Yes ☐ No

If yes, please provide the dates and claim details :

Attached Bills *(Please attach all itemized bills. Bills older than 90 days will not be reimbursed)*

Name Service Provider	Service Date	Bill Amount	Already Paid by Insured
		Afl.	☐ Yes ☐ No
		Afl.	☐ Yes ☐ No
		Afl.	☐ Yes ☐ No
		Afl.	☐ Yes ☐ No
		Afl.	☐ Yes ☐ No
	Total Amount		

Instructions for Submitting a Claim

1. Complete the front and back side of this form.

2. Please use a separate claim form for each different illness, condition or injury.

3. Please use a separate claim form for each insured.

4. Attach original bills or scanned copy of original bills.

5. You must inform and authorize us if unpaid bills must be paid directly to the Medical Service Provider.

6. Please verify that the documents indicate your name, date of service, type of service, and the charge for each service.

7. If you have any questions please call the number shown on your certificate or email us at service@massyunited.com

Electronic Claims Payment *(Optional authorization to deposit the claim reimbursement into a bank account)*

Name Account Holder	Bank Name
Bank Account Number	Bank Address

Declaration and Authorzation

The undersigned certifies that the answers given on this claim form are truthful and hereby authorize all doctors or other persons who treated me and all hospitals or other institutions furnish full information (including full copies of their records) regarding this claim to MASSY UNITED INSURANCE ARUBA N.V. The undersigned further understands that he or she is financially responsible for charges not covered by the Policy.

Signature Insured	Date