Allied Insurance Company

Health Insurance Overseas Cashless Treatment Referral Form

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Patient Information

Name of Patient:	
Health Insurance Card No:	Passport No:
Name of the Policyholder:	
Date of Birth:	Sex:
Local Contact No:	
Overseas Contact No:	Email:

Treatment Information

Date of Departure:
Expected Date of Hospital Visit:
Diagnosis or H/O Presenting Complaints:
Consultation/Expected Treatment/Procedure:
Preferred Hospital/Country:

Documents required: ☐ Copy of Health Insurance Card ☐ Authorized Recent Medical Document

Please submit this form to Allied Health Claims Office (City Square, 3rd floor) and preferably email scanned application to cashless@alliedmaldives.net, 02 days before leaving for overseas treatment.
Note: Overseas cashless service is not available for Skin, Dental or Health Checkup treatments (Reimbursement only).

Declaration: I/We desire to effect with the Company an insurance, in the terms of the Policy used for this class of business and I/We warrant that the above statements and particulars are correct and complete. I/We agree that this proposal shall be the basis of the contract and part of the insurance between myself/ourselves and the Company.

Signature: Date:

FOR OFFICIAL USE ONLY

Case ID No:		Referral Letter No:	
Authorized Letter No:		Policy No:	
Policy Period:		Policy Terms & Conditions:	
Policy Limits:	IP:	OP:	Critical:
Co-insurance:		Daily Room rate:	
Non Payable Items if any:			
Prepared By:		Authorized By:	

THIS INSURANCE WILL NOT BE IN FORCE UNTIL THE PROPOSAL HAS BEEN ACCEPTED BY THE COMPANY