



**International Assistance**  
Healthcare Anywhere, Anytime



Overseas Medical Check Up Form – Allianz Platinum

| No  | Details  |              |
|-----|--|--------------|
| 1.  | Full Name of Patient   |              |
| 2.  | Date of Birth  |              |
| 3.  | Gender   |              |
| 4.  | Identification Document/Passport                             | Provide Copy |
| 5.  | Nationality  |              |
| 6.  | Insurance Name & Card Number                                 |              |
| 7.  | Hospital Name  |              |
| 8.  | Type of Package  |              |
| 9.  | Check up Date  |              |
| 10. | Patient Contact Number(Local No at the country of Admission) |              |
| 11. | Email  |              |

The undersigned hereby gives his/her consent/power of attorney to medical service providers and treating physician(s) to release and share information about the state of health, medical treatment and report with the Insurance Company as stated above, International Assistance (other service providing partners) for the evaluation and assessment of above mentioned insurance event.

Note: This consent/power of attorney DOES NOT overrule the initial insurance agreement made between the insurance company and the policyholder/client.

Date: \_\_\_\_\_ Signature \_\_\_\_\_

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Insurance Partner:

