

ILLNESS/ACCIDENT
MEDICAL CLAIM FORM
(PLEASE USE BLOCK LETTERS)

Ref.: _____

Policy number: _____

INFORMATION ABOUT THE INSURED

First Name _____ Last Name _____

Address _____

Zip Code _____ City _____ Country _____

Date of birth _____ Gender M F Email _____

Tel _____ Mobile _____ Fax _____

IN CASE OF ILLNESS / INJURY

Describe the course of the illness / injury.(date, time, place, cause) _____

First symptoms _____

Have you previously suffered from the same complaints? No Yes, when (last time) _____

When/where did you find first medical help _____
Please include a medical report stating the diagnosis

Name of doctor, hospital, pharmacist...	Invoice nr.	Currency	Doctors' fee	Already Paid?

Please include all information from the doctor together with the original and receipted bills. The bills must state the dates of treatment and specify each individual amount.

Name of your family doctor _____

Address _____

Zip Code _____ City _____ Country _____

Tel _____ Mobile _____ Fax _____

 please consider the environment before printing this page. If not needed, don't print (just print page 1 and 3)

IN CASE OF A HOSPITAL ADMISSION

Date of admission _____ Date of discharge _____

Name of **the hospital** _____

Name of **treating doctor** _____

Address _____

Zip Code _____ City _____ Country _____

Tel _____ Mobile _____ Fax _____

Please include all information from the doctor/hospital together with the original and receipted bills. The bills must state the dates of treatment and specify each individual amount.

INFORMATION ABOUT OTHER INSURANCE OR SOCIAL SECURITY

Do you have a similar cover with another insurance company or social security institution (Health Fund, Mutuelle, Krankenkasse)? No

Yes, name of company or institution _____ Policy or Soc. Sec. N° _____

Address _____

Zip Code _____ City _____ Country _____

Has the claim been reported to the other company/institution? No, because _____

Yes, send us evidence of the company or institution refund.

IN CASE OF AN ACCIDENT

Describe the situation _____

Please include a police report, and a sketch of what happened

Name of **witnesses**, if any _____

Address _____

Zip Code _____ City _____ Country _____

Tel _____ Mobile _____ Fax _____

Name of the opposite party, if any _____

Address _____

Zip Code _____ City _____ Country _____

Tel _____ Mobile _____ Fax _____

His insurance company _____ Country _____ Policy number _____

