

Claim ref :	Reception date :
-------------	------------------

A

GENERAL INFORMATION

- ▶ **1 • The patient**
 - a - Name: _____
 - b - First name: _____
 - c - Birth date: Day Month Year
 - d - Certificate of Insurance number:

- ▶ **2 • Correspondence information** (please specify the country and city code)
 - a - Postal address:
 - Zip/City: Country:
 - b - Contact number: Tel. 1: Tel. 2: Fax:
 - c - E-mail:

- ▶ **3 • Your attending physician** (can be another physician than the one consulted for this affection)
 - Name and First name:
 - Address:
 - Zip/City: Country: Tel:

- ▶ **4 • Does this claim concern a follow-up treatment of an affection already declared to Golden Care?** Yes No
 If Yes, please specify claim reference number:

- ▶ **5 • Do you have another insurance policy covering the medical costs of this claim?** Yes No
 If Yes, please include the original detailed account of settlements already made and copies of the prescriptions, bills and other relevant supporting documents.

B

MEDICAL INFORMATION

- ▶ **1 • In case of accident**
 - a - Date of accident: Day Month Year **b - Country of accident:**
 - c - Nature of injuries:
 - d - Circumstances of the accident (exact cause and place):
 - e - If a third party is involved, please specify: Name and First name:
 Address:
 Zip/City: Country: Tel:

- ▶ **2 • In case of illness**
 - a - Date at which first symptoms appeared: Day Month Year
 - b - Nature of illness:
 - c - Have you already been treated (including prescribed medicines) for this condition or any related condition prior to your subscription to the Plan? Yes No If Yes, please specify:
 Date of treatment: Day Month Year Treatment followed:
 - Physician who treated you at the time: Name and First name:
 Address:
 Zip/City: Country: Tel:

- ▶ **3 • In the event of dental treatment** (if you benefit from this option)
 - a - Does this treatment concern: routine dental treatment? dental prosthesis?
 - b - Have you ever received any treatment in relation with this event? Yes No
 If Yes, please specify: Date of treatment: Day Month Year
 Treatment followed:

- ▶ **4 • In the event of maternity** (if you benefit from this option)
 - a - Date of the last menstruation: Day Month Year
 - b - Expected date of delivery: Day Month Year



YOUR CLAIM

1 • Reimbursement

a - What are the medical costs incurred?

Detail of medical expenses	Total amount paid	Currency of payment
Consultation fees		
Prescription drugs		
Medical examination tests (laboratory, X-rays...)		
Hospital charges		
Additional expenses covered by the Plan		
Total medical expenses claimed		

b - Reimbursement by: Cheque Credit transfer

c - Name and First name of the beneficiary of reimbursement:.....

d - If address where the cheque should be sent is different from the postal address (section A), please specify:

Address:

Zip/City:..... Country:

e - To which bank should the payment be transferred? Bank name:

Address :

Zip/City:..... Country:

Account number:..... Bank sort code:

Please include with original copy of this claim form:

- the Medical Information slip(s) completed by the consulted physician(s),
- the original copies of all prescriptions, bills, and other relevant supporting documents.

2 • Direct settlement (direct settlement may be made exclusively to a hospital or maternity ward, in the event of hospitalisation or delivery)

a - Physician having ordered hospitalisation or admission to a maternity ward: Name and First name:.....

Address:

Zip/City:

Country:Tel.:Fax:

b - Hospital or maternity ward you shall be admitted to: Name:.....

Address:

Zip/City:..... Country:

Contact: Tel. 1:.....Tel. 2:Fax:

c - Date of admission: Day [] [] Month [] [] Year [] [] [] [] d - Scheduled length of stay:.....

e - Estimated total amount of hospitalisation costs and consultation fees:.....

Please include with original copy of this claim form:

- the Medical Information slip completed by the physician having ordered hospitalisation or admittance to a maternity ward,
- the original copies of all other relevant supporting documents.

3 • Prior Approval (prior approval is compulsory for the reimbursement of certain pathologies and/or services as mentioned in the General Conditions of your contract)

a - Treatment concerned?

b - Physician having ordered necessary treatment:

Name: Tel./Fax/E-mail:

Please include with original copy of this claim form:

- the Medical Information slip completed by the physician having ordered necessary treatment,
- the original copies of all prescriptions and other relevant supporting documents.

Declaration : I hereby authorise to be submitted any medical information necessary for the handling of my claim. I declare the above information full, complete, and to the best of my knowledge, exact.

Signature of Insured or legal representative



Date: Day [] [] Month [] [] Year [] [] [] []

Send your claim to: Golden Care Service