

## REIMBURSEMENT, DIRECT SETTLEMENT OR PRIOR AGREEMENT

### A GENERAL INFORMATION

#### 1 • The patient

a - Name, first name: .....

b - Date of birth:

c - Insured number (on the card):

#### 2 • Does this claim concern a follow-up treatment of an affection already declared to Golden Care ?

Yes N° : .....  No

#### 3 • Do you have any other insurance policy covering the medical costs for this claim ? Yes No

If yes, please include the original details 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:

b - Exact circumstances of the accident: .....

.....

.....

c - Is a third involved ? :  Yes  No

d - At the time of the accident, were you officially employed :  Yes  No

Name and address of your employer: .....

e - Was there any official police registration of the accident :  Yes  No      If yes, please join a copy.

#### 2 • In case of illness

a - Date of the first symptoms:

b - Nature of illness: .....

Treatment: .....

.....

#### 3 • In the event of dental treatment (if you have this option)

a - Does this treatment concern:  Routine dental treatment  Dental prosthesis

b - Is your dental treatment following an accident:  Yes  No

c - Have you already received any treatment in relation with this even ? :  Yes  No

If yes, please specify:

Date of the treatment:

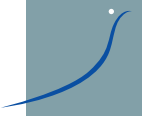
Treatment: .....

#### 4 • In the event of maternity (if you have this option)

a - Date of your last menstruation:

b - Expected date of delivery:

c - Expected place of delivery: .....



## C YOUR CLAIM

### ▶ 1 • Reimbursement

**a** - In which currency would you like to be reimbursed (if you have this option):  CHF  EUR  USD

**b** - Modality of reimbursement:

Credit transfer:

Name of the bank: .....

Address: .....

Zip/City: ..... Country: .....

Account number: ..... Bank sort code/Clearing: .....

Iban: ..... Bic/Swift: .....

### ▶ 2 • Direct settlement (direct settlement may only be given to a hospital or maternity ward, in event of hospitalization or delivery)

**a** - Physician name: .....

Address: .....

Zip/City: ..... Country: .....

Tel.: ..... Fax: ..... E-mail: .....

**b** - Name of the hospital: .....

Address: .....

Zip/City: ..... Country: .....

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

**c** - Date of admission:

**d** - Scheduled length of stay: .....

### ▶ 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: .....

Address: .....

Zip/City: ..... Country: .....

Tel.: ..... Fax: ..... E-mail: .....

**Declaration:** I hereby authorise the release of any medical information necessary for the handling of my claim. I declare the above information as accurate and complete to the best of my knowledge.

Date:

**Signature of Insured or legal representative**

**Send your claim to:**

**Safe MedCare SA – Medical Service**  
**5, Esplanade de Pont-Rouge, CH – 1212 Lancy**  
**Switzerland**

**Safe MedCare SA - Centre de gestion et d'administration médicale et d'assistance**

5, Esplanade de Pont-Rouge, CH – 1212 Lancy, Switzerland – Tel. : +41 22 786 12 00 – Fax: +41 22 786

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