Golden Care® Declaration Form

YOUR HEALTH ins URAnc E AROUn D THE WORLD

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 detailes 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 : .....

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YOUR HEALTH INSURANCE AROUND THE WORLD

C YOUR CLAIM

1 • Reimbursement

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

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 : ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋⌊_⌋⌊_⌋

Send your claim to: Safe MedCare SA

Signature of Insured or legal representative

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