EXPAT & CO
smart insurances

DISABILITY CLAIM FORM

(PLEASE USE BLOCK CAPITALS)

Policy number .....

INFORMATION ABOUT THE INSURED

First Name ..... Last Name .....

Address .....

.....

Postal Code ..... City ..... Country .....

Date of Birth (dd/mm/yyyy) ..... Gender M ◯ F ◯

Email .....

Tel* ..... Mobile* .....

**please include country codes*

INFORMATION ABOUT YOUR WORK

Job Description .....

Employer .....

Employer address .....

Since ..... Hours/week ..... Employed ◯ Self-employed ◯

INFORMATION ABOUT THE DISABILITY

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

.....

.....

First symptoms .....

Have you previously suffered from the same complaints? No ◯ Yes ◯ , when .....

When/where did you find first medical help .....

Are you treated in a hospital? No ◯ Yes ◯ , from 'till .....

Name of the hospital .....

Address .....

Postal Code ..... City ..... Country .....

Tel* ..... Email .....

Name of the treating doctor .....

Last working day (dd/mm/yyy) .....

Prognosed return to work (dd/mm/yyyy) .....

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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. No .....

Address .....

Postal Code ..... City ..... Country .....

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

◯ Yes, please send us evidence of the company or institution refund

REIMBURSEMENT METHOD

The amount should be reimbursed to ◯ Policyholder ◯ Insured ◯ Other

Please transfer reimbursement to my account in ..... (country)

Name of bank .....

Address .....

IBAN ..... BIC/SWIFT code, ABA, if any .....

Account No ..... Account holder .....

MUST BE SIGNED BY THE INSURED

I, the undersigned, declare that all information given in this claim form is in accordance with the truth and that nothing is concealed. I authorise Expat & Co and the insurance company to obtain information from any doctor, hospital or insurance company concerning myself or any co-insured persons in order to process the claim in accordance with the Policy Conditions.

I hereby give Expat & Co the authority to recover any reimbursement, advanced by them, from any other insurance company or social security institution which can give a right to reimbursement as a consequence of this claimed illness, injury or accident.

I hereby accept that Expat & Co and the insurance company will record the information given for the purpose of processing data in connection with e.g. premium collection, processing of claims, reimbursements, etc. In case of non-acceptance of the request for reimbursement, the information given may be recorded. Furthermore, I accept that insurance correspondence which does not contain health information or other sensible information is sent to the person registered as the policy holder. Expat & Co or the insurance company may choose to have data processed in or outside the EU.

Date ..... Signature .....