swisscare

Claim form

Policy nr.

Please complete the following claim form and send it back to our claim service partner **Intrust**
Instructions and address are at the second page

INSURED PERSON

LAST NAME	**First name**
Gender Male ( ) Female ( )	**Date of birth** (dd/MM/YYYY)
Email	**Phone number**
Address	**Zip / City**
Country of permanent residency	**Occupation**

BANK ACCOUNT FOR REIMBURSEMENT (Attention: please fill in all the details carefully)

Bank holder name + full bank address Same as insured person ( )

Bank name + full bank address	**IBAN** **Swift / BIC**

Are there any other insurers covering and/or reimbursing the costs for this claim? Yes ( ) No ( )

In the affirmative, please send us the coordinates of these insurers as well as the detailed accounts of any settlements already made and copies of medical prescriptions, invoices and other relevant supporting documents.

IMPORTANT :

1.Did you have already made a claim to this policy within the last 12 months or does this claim concern a follow-up treatment of an affection already declared to the Claims Department?

Yes ( ) Claim nr. No ( )

2. Is the related treatment received due to alcohol or drug abuse?

Yes ( ) No ( )

ILLNESS (maternity not covered)

Type of illness / Diagnostic	**Date/time first symptom**

Description

Have you already received medical care (including prescribed or bought medicine) for this illness or any potentially related health condition? Yes ( ) Date of treatment No ( )

Name of the treatment received

Name, address, phone, email, fax of the physician

ACCIDENT

Date of the accident	**Place of accident**

Circumstances

swisscare

Nature of the injury

Other involved person Yes ( ) No ( ) If yes, please indicate the complete address, phones, emails….

Police or emergency unit report Yes ( ) No ( ) if yes, please enclose the report

Important: Direct settlement may only be given to a hospital, in case of hospitalisation or childbirth. The prior approval is compulsory for the reimbursement of certain services as mentioned in the general insurance conditions.

OTHERS

Date of the event	**Place of event**

Circumstances

Nature of the event

CONFIRMATION

All documents provided must be translated into English at the insured's own expenses. The insurer reserves the right to refuse refunds if the required documents are not translated.

I confirm that I attached all as indications below (all must be ticked to be reimbursed)

( ) Detailed invoice **or** invoice with medical report	( ) Proof of payment (bank, cash, credit card receipt)
( ) Physician prescription(s)	( ) Diagnostic of the illness, accident or maternity
( ) Bank holder and bank name complete details	( ) Claim form completed

Date **Signature**

IMPORTANT INFORMATION

In order to get refunded as quickly as possible, send us all the necessary documents stated above. Each new event in case of sickness, accident, maternity needs a separate claim form.

Complete bank details are required. Bank name or holder without full address can block the transaction(s).

To avoid high bank fees, we suggest that you collect your invoices for reimbursement and send it together with the claim form to our claims management.

ADDRESS FOR SENDING CLAIM FORM

By scan : **studentpassin-claims@swisscare.com**

By postal mail at the following correspondence address :

inTrust
Cunningham Lindsey Zorn GmbH,
Wilhelmstraße 96,
42489 Wülfrath,
Germany

(the company reserves the right to request originals)

In case of emergency, hospital admission or pre-approvals, please contact :

Alarm center 24 / 7 +49 69 977 88 99 99 9

ANKER INSURANCE