swisscare

Claim form

Policy nr.

Please complete the following claim form and send it back by email to **sc-claims@de.sedgwick.com**
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**

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

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

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….

PRIVATE LIABILITY

Date of the event **Place of event**

Circumstances and nature of the event

Claimant name

Address

Phone number **Email**

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

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.
I authorize –revocable at any time- (1) Cooper Gay and third parties commissioned by them (such as Sedgwick and others) to collect, process and use my personal data as well as the release of any medical information necessary to process this claim and (2) the processing of any medical information or other personal data provided by me or by my physician/dentist and the disclosure of such information to underwriters via claims handling agents as well as the medical assistance provider and, where relevant to loss adjusters for the purpose of this claim. Unless you give consent to this authorization, we are not able to process your claim.
I content – revocable at any time- that my health data and other personal data may be transferred to Swiss Care and that it may be processed and utilized there in order to evaluate my entitlement or to be forwarded to other responsible insurers for claiming my entitlement. Where required, I release all persons employed by Cooper Gay, Sedgwick and others from their obligations of confidentiality in regards to my health data and any other personal data that is protected by law.

Date **Signature**

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

Alarm Service 24/7 +49 (0) 211 5401 4750

Questions for your claim already reported or if there is no emergency,please contact

Telephone: +49 (0) 211 54014239

ADDRESS FOR SENDING CLAIM FORM BY SCAN

By scan : **sc-claims@de.sedgwick.com**
By postal mail at the following correspondence address :

Claims Department
Sedgwick Germany GmbH
Gladbecker Straße 1
40472 Düsseldorf, Germany

(the company reserves the right to request originals)

Cooper Gay