Medical Claim Form

1. Please write clearly in black ink and **block capitals**.
2. This claim form contains personal data. Please do not share this with members outside your family.
3. Please complete a separate claim form for each patient and for each currency.
4. Return this form with original invoices (no staples) to: hopehealthinsurance1@gmail.com

Name plan member

Personal reference n° /

Organization

Patient

Name

Date of birth D M Y Gender ◯ M ◯ F

Address

Telephone

Email

Project no.

Period of contract D M Y

CLAIM INFORMATION

Is the claim (partially) related to an accident? ◯ No ◯ Yes ◯ Yes, work related

↳ If yes, also complete the **Notification of accident form**.

Is the claim covered by another insurance? ◯ No ◯ Yes

↳ If yes, specify the amount and the insurance company and include the insurance statements (settlement notes, invoices, etc.)

Amount and currency | Insurance company

Currency	Amount	Invoice date	Nature of expenses	Diagnosis
		D M Y		
		D M Y		
		D M Y		
Total		Main country of treatment		

PAYMENT INFORMATION - COMPLETE ONLY IN CASE OF CHANGE

◯ Mail cheque to Name

Address

◯ Bank transfer Preferred currency of reimbursement

The currencies are limited by the contract. If this currency is different from that of your bank account, your bank could charge you fees at your expense.

Name account holder

Account n° or IBAN

BIC/Swift code | Bank ID

Full bank name and address

In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent regarding the processing of the medical data concerning myself and/or the members of my family (article 7 of the Belgian law of December 8, 1992 concerning the private life). I certify that the above information is to the best of my knowledge and belief correct and true. The issuance of false claims, the provisions of misleading information or the withholding of information related thereto is an offence punishable by Law. The information provided on or attached to this form may be disclosed to other persons or entities for the purpose of processing this claim and performing medical insurance plan administration.

Date D M Y | Signature of the plan member

Hope insurance Management System

Contact no:04198766318