

# NHC CLAIMS FORM

|                 |            |                          |  |  |
|-----------------|------------|--------------------------|--|--|
| Policy number   |            | Date of birth (DD-MM-YY) |  |  |
|                 |            |                          |  |  |
| First name(s)   | Surname(s) |                          |  |  |
| Address/country |            |                          |  |  |
|                 |            |                          |  |  |
| Phone           | E-mail     |                          |  |  |
|                 |            |                          |  |  |

## Claims type (tick off)

Illness/injury     Dental     Medical escort/summoning     Curtailment

## Illness/injury

Reason(s) for medical treatment/diagnosis?

When did the illness/injury occur?

Have you suffered from the same illness previously? If yes, when?

Name/address of treating hospital/doctor?

Signature of treating doctor

## Curtailment

Reason for curtailment?

Your relation to the person in question?

*Please attach medical certificate or death certificate alongside documentation for your expenses.*

## Other insurance

Are you covered by a health insurance with another company?     No     Yes

If yes, please state name/address of insurance company \_\_\_\_\_

\_\_\_\_\_ Policy number? \_\_\_\_\_

## Reimbursement

Reimbursement will be paid directly into a bank account of your choice, if you state the required details below:

Bank registration/account number \_\_\_\_\_

IBAN number \_\_\_\_\_ SWIFT code \_\_\_\_\_

Bank name/address \_\_\_\_\_

I wish to have the reimbursement registered as partial premium payment     No     Yes



**NORDIC**  
HEALTH CARE

**Consent**

I accept that Nordic Health Care may send and collect information concerning my health from authorized medical staff, hospitals, health care institutions, public authorities, insurance companies and the like in order to verify this claim. My consent extends to said diagnosis/injury only.

I declare that the information given is truthful and complete and in good faith. I understand that erroneous information may result in the termination of the insurance policy as well as my paying for said damages myself.

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Date

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Signature

**Claim(s)**

| Reason for medical treatment (diagnosis): | Currency and amount: |
|---|----------------------|
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**Please enclose original documentation.**

