Claim Form Medical Insurance - Expatriates

EUROPEISKE REISEFORSIKRING
– a part of the If-group

Name of claimant

Social security number

Is the claimant ☐ Employee's spouse ☐ Employee's child

Policy number

Claim number (will be filled in by us)

Temporary address abroad

If payment to an account outside Norway, please make sure that all necessary information is stated below.

Zip code / district / country

Bank account number

Home country address

IBAN

Zip code / district

SWIFT/BIC

E-mail address (will be registered in our database)

Bank name

Home tel. | Office tel. | Cell phone

Bank addresss

Name of employee

Name of employer

Stationed

Last departure from home country: Day Month Year

First planned return home: Day Month Year

If yes;

Date of departure: Day Month Year

Date of return: Day Month Year

Were you on a vacation? → ☐ No ☐ Yes

Did you pay your tickets with a credit card? → ☐ No ☐ Yes

If yes; please enclose a copy of the invoice

Card number

Do you have other insurances covering medical expenses? → ☐ No ☐ Yes

If yes; name of company

Policy number

Have you claimed other insurances for this expense? → ☐ No ☐ Yes

If yes; name of company

Policy number

Are you a member of NAV National Office for Social Insurance Abroad? → ☐ No ☐ Yes

Illness / injury

When did the injury/illness occure? → Day Month Year

Where did the illness/injury occure?

Name of medical provider (physisian, hospital etc)

Provider's adress and phone number

Have you previously been treated for this illness? → ☐ No ☐ Yes

If yes; when

Name of medical provider

Have you previously claimed compensation for medical expenses? → ☐ No ☐ Yes

If yes; which insurance company compensated your claim?

What illness/injury justifies your claim? If it is an accident, please explain how it happened and to what extent your injuries are caused by this incident?

(If necessary, please continue on the other side)

Turn

Bl.nr. 37006e. Printing AS

YOUR CLAIM		Currency	Amount
Out-patient treatment →	Number of visits		
Prescribed medication →			
Transport expenses to/from physisian/hospital →			
Hospital accommodation →	Number of days		
Hotel accommodation →	Number of days		
Home care →	Number of days		
Repatriation →			
Summoning of close relatives →			
Home call →			
Return journey →			
Other expenses Please specify: →			

For documentation of your claim, please send original invoices, medical certificates, prescriptions etc. as soon as possible.

DECLARATION OF APPROVAL

I hereby confirm that I was not aware of any medical treatment needed before my stationing. I hereby autorize Europeiske to request additional information from doctors/hospitals concering this case.

Signature

Place	Date	Signature of the claimant
Place	Date	Signature of employee (if this is not the claimant)

I hereby confirm that the above information is correct. I am aware that any fraud against the insurance company will divest me any right to compensation. (See general conditions.)

Comments /complementary text (continuation from first page)