Student travel –

Medical expenses

claim form (short version)

**Address**: ACE European Group Limited, Claims Department, Avenue des Nerviens 9-31, box 7, 1040 Brussels, Belgium. **Email**: beneluxclaims@acegroup.com **Tel**: +32 (0)2 516 97 83

|  |
| --- |
| **Important:** |
| - Fill in all applicable questions as completely as possible; this will avoid delays in the claim handling process. |
| - We prefer receiving your claim by e-mail. If you decide to send your documents by e-mail, please remember to keep the original documents, as we may still ask for them for verification purposes. You can of course send your claim by post, if you prefer. |
| - Make sure to enclose any declarations, deeds and other evidence right from the start. |
| - Make sure your answers are clearly readable, please use capital letters. |
| - Make sure to sign the form after completing it. Unsigned forms will not be handled. |

# General

|  |  |  |  |
| --- | --- | --- | --- |
| Policy number:  |  | E-mail address: |  |
| Name and Surname: | Ms. / Mr.\* |  |
| Address for correspondence: |  |
| Postal code: |  | Town/City: |  |
| Telephone:  |  | Date of birth: |  |
| Bank account number / IBAN: |  |
| BIC/SWIFT code of the bank: |  |

*\* Strike out what does not apply.*

# Medical expenses

|  |  |  |
| --- | --- | --- |
| **B1** | **The claim concerns:** | **Accident / Illness\*** |
|  |  | *\* Strike out what does not apply.* |
| **B2** | **When did you have the first medical symptoms?**  |  |
| **B3** | **Circumstances and description of the medical complaints (Describe the symptoms and the diagnosis if already known. If necessary, enclose a diagram and/or explanation of the situation on the back of this form):** |
|  |  |
|  |  |
|  |  |
|  |  |
| **B4** | **Are you still being treated?** |  Yes/No\* |
| **B5** | **In case of an accident, is there question of potential permanent invalidity?** |   Yes/No\* |

|  |  |  |
| --- | --- | --- |
| **B6** | **In your opinion, is a third party liable for the damages incurred?**  |  Yes/No\* |
|  | If yes, | Name:  | *\* Strike out what does not apply.* |
|  |  | Address: |  |
|  |  | Telephone: |  |
|  |  | Why, in your opinion, is the third party liable?  |  |
|  |  | With which company is the third party insured? |  |
|  |  | Company:  |  | Policy number: |  |
|  |  | What is the relation between yourself and the third party?  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Invoice № \*\*** |  | **Name of doctor/pharmacy** |  | **Amount in foreign currency** |  | **Amount in euro** |  | **Amount reimbursed by Social Security** |
| 1. |  |  |  |  |  |  | € |  |  |
| 2. |  |  |  |  |  |  | € |  |  |
| 3. |  |  |  |  |  |  | € |  |  |
| 4. |  |  |  |  |  |  | € |  |  |
| 5. |  |  |  |  |  |  | € |  |  |
| 6. |  |  |  |  |  |  | € |  |  |
| 7. |  |  |  |  |  |  | € |  |  |
| 8. |  |  |  |  |  |  | € |  |  |
| 9. |  |  |  |  |  |  | € |  |  |

*\*\* Please send the invoices and the related medical documentation.*

|  |
| --- |
| **Are you insured by a health care insurer (Social Security)?** **Yes / No\*\*\***\*\*\*If so, please send to ACE Europe the statement of (reimbursement or the lack thereof) by your health care insurer. |

The personal information is collected and held by ACE European Group Ltd., Avenue des Nerviens 9/31 - 1040 Brussels, for the general management of the customers relations, the sale and the commercialization of insurances. Following the Belgian Law of protection of private life, of 8 December 1992, you have the right to consult the information concerning yourself as well as the right to rectify any possible erroneous, incomplete or irrelevant information relative to your person. For this purpose, please send a letter by registered post to the file administrator: ACE European Group Ltd.

**The undersigned declares:**

* that he/she answered the above questions and provided the above particulars accurately, truthfully and to his/her best knowledge, and that he/she has not withheld any potentially important information relating to this claim;
* that he/she submits this claim form and any additional information to the insurer for the purpose of determining the extent of the damage or loss and the entitlement to benefit;
* that he/she has taken note of the content of this form;
* that he/she accepts to provide the medical advisor of ACE European Group Ltd., if necessary, all additional information that the advisor deems necessary for the handling of this claim.

Date *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* City *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Signature *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*