

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?

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 _____



