



Golden Care® Declaration Form

YOUR HEALTH INSURANCE AROUND THE WORLD

1/2

REIMBURSEMENT, DIRECT SETTLEMENT OR PRIOR AGREEMENT

A GENERAL INFORMATION

1 • The patient

a - Name, first name:

b - Date of birth: [][] [][] [][][][]

c - Insured number (on the card): [][][][][][][][]

2 • Does this claim concern a follow-up treatment of an affection already declared to Golden Care ?

Yes N° : No

3 • Do you have any other insurance policy covering the medical costs for this claim ? Yes No

If yes, please include the original details account of settlements already made and copies of the prescriptions, bills and other relevant supporting documents.

B MEDICAL INFORMATION

1 • In case of accident

a - Date of accident: [][] [][] [][][][]

b - Exact circumstances of the accident:

.....

.....

c - Is a third involved ? : Yes No

d - At the time of the accident, were you officially employed : Yes No

Name and address of your employer:

e - Was there any official police registration of the accident : Yes No If yes, please join a copy.

2 • In case of illness

a - Date of the first symptoms: [][] [][] [][][][]

b - Nature of illness:

Treatment:

.....

3 • In the event of dental treatment (if you have this option)

a - Does this treatment concern: Routine dental treatment Dental prosthesis

b - Is your dental treatment following an accident: Yes No

c - Have you already received any treatment in relation with this even ? : Yes No

If yes, please specify:

Date of the treatment: [][] [][] [][][][]

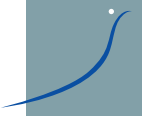
Treatment:

4 • In the event of maternity (if you have this option)

a - Date of your last menstruation: [][] [][] [][][][]

b - Expected date of delivery: [][] [][] [][][][]

c - Expected place of delivery:



— C YOUR CLAIM

► 1 • Reimbursement

a - In which currency would you like to be reimbursed (if you have this option): CHF EUR USD

b - Modality of reimbursement:

Credit transfer:

Name of the bank:

Address:

Zip/City: Country:

Account number: Bank sort code/Clearing:

Iban: Bic/Swift:

► 2 • Direct settlement (direct settlement may only be given to a hospital or maternity ward, in event of hospitalization or delivery)

a - Physician name:

Address:

Zip/City: Country:

Tel.: Fax: E-mail:

b - Name of the hospital:

Address:

Zip/City: Country:

Tel. 1: Tel. 2: Fax:

c - Date of admission:

d - Scheduled length of stay:

► 3 • Prior approval (prior approval is compulsory for the reimbursement of certain pathologies and/or services as mentioned in the General Conditions of your contract)

a - Treatment concerned:

b - Physician having ordered necessary treatment:

Address:

Zip/City: Country:

Tel.: Fax: E-mail:

Declaration: I hereby authorise the release of any medical information necessary for the handling of my claim. I declare the above information as accurate and complete to the best of my knowledge.

Date:

Signature of Insured or legal representative

Send your claim to:

Golden Care – Medical Service

31 Boulevard Helvétique - 1207 Geneva - Switzerland

Golden Care SA - Centre de gestion et d'administration médicale et d'assistance

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