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HEALTH INSURANCE CLAIM FORM

IMPORTANT: Please complete form in full, failure to do so may delay payment of claim. Please use **BLOCK** letters. Proof of claim must be submitted within 90 days of first of accident of illness. In order for your health claim to be considered for reimbursement, you must complete and sign this claim form. Please mail or fax this completed claim form with itemized bills and receipts to the address or fax listed above.

When mailing, please tape small receipts to a letter or A4 paper. Please do not staple receipts to claim form. A separate claim form should be used for each patient and each medical condition.

Documents and signed claim forms can be scanned and emailed to: healthcare@lampinsurance.com

Duration of trip: _____ Date of departure _____ Date of return _____
 Purpose of trip: leisure work education

Information of Insured:

Policy number: _____
 First name(s): _____ Date of birth (day/month/year): _____
 Family name(s): _____ Sex: Male Female
 Address: _____
 City: _____ Postal Code: _____
 Country: _____ Main contact number: _____
 Email: _____
 Student Travel Organisation: _____

Information about the claim:

This claim is for: illness injury accident other
 Where did the illness/injury/accident occur? _____ Date: _____
 How did it take place? _____

In case of illness/injury:

Please include a medical report stating the diagnosis and give your own full description of the course of the illness/injury (date of first symptom, etc.):

If you need extra space to give a full description, please continue on a blank piece of paper.

Have you previously had similar symptoms? Yes No
 If yes, which symptoms and when? _____
 Name of your doctor: _____
 Address: _____
 Telephone: _____

In case of accident:

Please include a police report and describe the situation with your own words: _____

If you need extra space to give a full description, please continue on a blank piece of paper.

Names and addresses of witnesses (if any): _____

In case of treatment by a doctor:

Date(s) of treatment: _____ Name of doctor: _____
 Address: _____
 Telephone: _____ Fax: _____
 Email: _____

Please include all information from the doctor together with the original and receipted bills. The bills must state the dates of treatment and specify each individual amount.

In case of treatment at a hospital or an emergency room:

Date treatment began: _____ **Date of discharge:** _____
Name of hospital: _____
Name of treating doctor: _____
Address: _____
Telephone: _____ Fax: _____
Email: _____

Kindly include all information from the hospital together with the original and receipted bills. The bills must state the dates of treatment and specify each individual amount.

Specification of expenses (if bills are included):

Amount in local currency: _____
Amount in reimbursement currency: _____
Please include all the original bills and a list where you specify the expenses.

Reimbursement:

Please include the original itemised and receipted bills and travel documentation

The amount should be reimbursed to: Policyholder Other
Amount: _____ Currency: _____
The amount should be reimbursed by: Cheque Bank Transfer
Name of bank: _____
Address: _____
BIC/S.W.I.F.T Code/ABA, if any: _____
IBAN: _____
Account number: _____
Account holder: _____

Information about other insurance:

Do you have similar insurance with another company? Yes No
If yes, name of company: _____
Address: _____
Policy number: _____ Has this claim been reported to the other company? Yes No

Policy holder or authorised person's Signature and Release (to be completed by the Parent or Legal Guardian if claim is for a minor):

I certify, to the best of my knowledge, that this Claim Form does not contain any false misleading or incomplete information. I authorise the release of all records or other information that may be necessary to determine benefits payable.

Signature: _____ Date: _____
Print name: _____
Are you the insured: Yes No If no, relationship to insured: _____