NHC CLAIMS FORM

Policy number		Date of birth (DD-MM-YY)
First name(s)	Surname(s)	
Address/country		
Phone	E-mail	

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?

Signature and stamp of treating doctor

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:

Account holder ______________________

Bank registration/account number ______________________

IBAN number ______________________

SWIFT code ______________________

ABA / Routing number ______________________

Bank name/address ______________________

I wish to have the reimbursement registered as partial premium payment ☐ No ☐ Yes

NORDIC HEALTH CARE

Consent

I accept that Nordic Health Care may send and collect information concerning my health from authorized medical staff, hospitals, health care institutions, public authorities, insurance companies and the like in order to verify this claim. My consent extends to said diagnosis/injury only.

I declare that the information given is truthful and complete and in good faith. I understand that erroneous information may result in the termination of the insurance policy as well as my paying for said damages myself.

________________ ________________________________

Date Signature

Claim(s)

Reason for medical treatment (diagnosis):	Currency and amount:

Please enclose original documentation.

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NORDIC
HEALTH CARE

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