

Corporate Expat Insurance

Claim form for medical expenses etc.

Policy No.:

Claim No.:

The claim for compensation is regarding (please tick off the box)			
Escort/summoning	Curtailment/replacement employee	Ruined holiday	Dental treatment
Illness/injury	Life insurance/permanent disability	Repatriation	
Name of your firm:		What is your job title?	
Name of Contact Person (firm):		E-mail of Contact Person (firm):	
First name(s), surname:		Date of birth:	
Street address:		Postal code:	City:
E-mail:	Phone:	Mobile:	Home: Work:
Local insurance details			
This information is a condition for handling your claim.			
Please state the name of your local insurance policy:			
Please state the policy number of your local insurance policy:			
Is your claim reported to your local insurance policy?			
Please state the amount reimbursed by your local insurance policy:			
Travel details			
Date of departure:	Date of return:	Destination (city and country):	
What is the purpose of your journey?		Airline company/travel agent:	
What happened?			
Where and when did the claim occur? Date: Time: Location (city and country):			
Description of what happened – as detailed as possible (please enclose further description):			
To be filled out if you had a personal accident or was assaulted			
Were there any witnesses to the incident?			
Yes	No	Name(s) and address(es):	
Has the incident been reported to the police?			
Yes	No	If no, why not?	
To be filled out if your claim is regarding curtailment			
What/who was the cause of the curtailment?			
How is/was the person related to you?			
Documentation for the curtailment such as medical journal or death certificate and documentation for the expenses claimed must be enclosed along with your claim form.			
To be filled out if your claim is regarding replacement employee			
How many days were you unable to work?			
Medical certificate stating diagnosis and the expected duration of the inability to work and documentation for transportation expenses must be enclosed along with your claim form.			

Details of treatment				
Treatment date:		Dates of hospitalisation:		
Diagnosis/description of the illness:				
Have you previously been treated for the same illness? Yes No				
If yes, state the date on which you last received treatment:				
Were you repatriated? Yes No If yes, when?				
By who? Yourself ERGO Forsikring				
Your general practitioner/dentist: Name:		Phone No.:		
Address:		Postal code/city:		
To be filled out if your claim is regarding dental treatment				
Did you seek dental treatment abroad?				
Yes No If no, why not?				
Alarm centre				
Has ERGO Forsikring's alarm centre been notified about the claim? Yes No If yes, case No.:				
Has ERGO Forsikring's service offices (Euro-Center) been notified about the claim? Yes No If yes, case No.:				
Compensation claimed				
Please enclose documentation		Foreign currency	DKK	Is the compensation to be paid directly to the provider? (x)
Physician's fees:	Number of treatments/consultation:			
Medicine prescribed by a physician				
Transport expenses				
Hospitalisation		Number of days:		
Extra hotel expenses		Number of days:		
Other extra expenses for illness/injury	Please specify:			
Expenses for escort/summoning	Please specify:			
Expenses for curtailment/replacement employee	Please specify:			
How many days were you ill?				
Signature etc.				
<p>I hereby declare that the given information is true. I am aware that ERGO Forsikring's coverage can be reduced or waived according to law, if I state untrue information.</p> <p>I hereby give my consent to ERGO Forsikring to collect, use and keep my personal health information and to disclose this health information to authorised persons within the health care sector, hospitals and health care institutions, public authorities, insurance companies/pension funds, The Insurance Complaints Board, Labour Market Insurance etc. The consent/power of attorney only covers this claim.</p> <p>Remember that you, at any time, can withdraw your consent by contacting ERGO Forsikring and stop any future use of your consent. Read more about your rights on our website at www.erv.dk under "Data Protection Policy".</p> <p>Please note, that withdrawing your consent may influence our capability to process your application and that we are bound by rules and legislation regarding storing and filing of your data from the time you conclude a valid insurance contract with us.</p>				
Insured's signature			Date	
Signed and stamped on behalf of the firm			Date	