CLAIM FORM MEDICAL COSTS
STUDENTS FROM SINT MAARTEN

PERSONAL DATA

Policy number *insurance period from* *to*

_____

Name and initials *Date of birth*

_____

Address *City* *Postcode*

_____

Telephone *Country*

_____

IBAN account *Name of account holder*

_____

Email

_____

Symptoms

Date and descriptions of symptoms

_____

In case the symptoms are a result of an accident

Date and description of the accident

_____

Have you suffered from the symptoms before? If yes, when?

_____

Invoices

Name doctor/hospital *date of invoice* *amount* *payment to myself yes/no*

_____

_____

_____

_____

_____

Please clearly indicate by payment to myself yes/no, so we know to whom we should pay the invoice(s).
Please enclose originale invoices.

The undersigned declares that he/she has answered the above questions and provided the above particulars accurately, truthfully and the best of his/her knowledge, and that he/she has not withheld any particulars relating to this claim.

The undersigned also hereby authorises the medical advisor of InsureToStudy to obtain any desired information from the attending physician(s). This said physician is also hereby authorised to provide any information relating to this claim.

Signature insured Date Place

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