

CLAIM FORM (YOUNG) GLOBAL TRAVELER

(Also to be downloaded from www.oominsurances.com)

IMPORTANT!

- Use a separate claim form for each insured.
- If there is not enough space on this form, please annex the necessary explanation.
- Forms not completely filled in and/or not signed, will not be taken up.
- When the total amount of the invoices exceeds the own risk, please send in the claim form with the original invoices as soon as possible.
- The (Young) Global Traveler insurance is based upon the **claim principle**. This means that the **insured him/herself is responsible for the payment of the invoices**. When paid, the invoices can be claimed at our company. Any administration and/or collection fees will not be reimbursed.
- Send in only original invoices. Duplicates, copies, reminders and/or receipts, etc will not be taken up.
- Invoices must bear:
 - name (including first names and/or initials) and date of birth of the patient,
 - date of treatment and invoice date (dates in the Common Era),
 - invoice amount and currency.

Above data must be stated in an understandable language (i.e. English).
Medical statements, referrals, prescriptions and other pieces of evidence should be enclosed.
- We advise you to make copies of this claim form and the enclosed invoices for your own administration.

POLICYHOLDER

POLICY NUMBER:

Name and first names: (M/F)

Address:

E-mail:

Telephone no.: Fax no.:

INSURED PERSON WHO THIS CLAIM RELATES TO

Name and first names: (M/F)

Date of birth:

REIMBURSEMENTS CAN BE PAID TO

Account no. (Post)bank:

Name and town of the account holder:

In case of payments to a foreign (not Dutch) account number:

Name and town of the bank:

Swift code of the bank:

SPECIFICATION OF CLAIMED INVOICES

	Health care provider	Date of treatment	Currency	Amount	Accident
1.	yes / no
2.	yes / no
3.	yes / no
4.	yes / no
5.	yes / no
6.	yes / no
7.	yes / no
8.	yes / no
9.	yes / no
10.	yes / no

please fill in the other side

EXPLANATION**POLICY NUMBER:**

(to be filled in by the insured or his/her legal representative)

1. What complaints was insured treated for?
2. On what date did the complaints start?
3. On what date was a doctor consulted for the first time?
name + address doctor:
4. Did the insured consult other doctors? no yes, date:
name + address doctor:
5. Was insured treated for this before? no yes, date:
Explanation:
6. Has insured been hospitalized? no yes: please also fill in the form Notification of a Hospitalization.
(stay of more than 24 hours in a hospital) *(This form can be downloaded from www.oominurances.com)*
7. Is the complaint / ailment a result of:
a. sports? no yes: please describe the event below
b. an accident? no yes: please describe the event below and also fill in the form Notification of an Accident. *(This form can be downloaded from www.oominurances.com)*
Description with a and/or b:
8. a. *To be filled in when insured for region A and/or B:*
Upon permanent return to the Netherlands: Insured arrived in the Netherlands on
Upon temporary return to the Netherlands: Insured stays / stayed in the Netherlands from until
- b. *To be filled in when insured for region the Netherlands:*
Upon permanent departure from the Netherlands: Insured left the Netherlands on
Upon temporary stay outside the Netherlands: Insured stays / stayed outside the Netherlands from until
9. a. Is insured also insured elsewhere against medical expenses? no yes: Dutch national health insurance other:
Insurance company:
Policy number:
Insurance period: from until
- b. Can reimbursement be claimed under this other insurance? no yes
Explanation:
10. Are more claims to be expected regarding above mentioned ailments / complaints? no yes, explanation:
(i.e. because not all invoices are received or because insured is still being treated.)

Insured (name), born declares:

- to have answered above questions to his/her best knowledge, correctly and truthfully and not to have concealed any information in relation to this claim and to be aware of the fact that upon incorrect/incomplete/untruthful statement all entitlements to reimbursement shall lapse;
- to be aware that this claim form and any further information serve to determine the scale of the claim and the entitlement to reimbursement;
- to have taken note of the content of this form.

Signature:

The insured has to sign the form him/herself, unless he/she is not yet 16 years old, has been placed under guardianship or tutorship. In this case the form has to be signed by the legal representative.

Date: Town:

Name legal representative:

Only to be filled in if the insured is not yet 16 years old or if he/she has been placed under guardianship or tutorship.

Relation to insured (choose): father/mother – gardian – tutor