SWISS GLOBAL INSURANCE

MEDICAL EXPENSES CLAIM FORM - PROCEDURE FOR FILING A CLAIM

1.Please avoid making a series of small claims. It makes sense to accumulate your small medical and dental bills until you have enough to justify a significant reimbursement.

2.The claim form must be completed and sent by email to SGI International Services at claims@swissglobalinsurance.com along with scanned invoices and payment receipts as well as other relevant document justifying your request.

We suggest that you keep the originals as our claim department may request the originals at any time. Please follow the instructions on the form.

3.Bills for eyeglasses, contact lenses, prescription drugs, laboratory tests, physical therapy or chiropractic treatment must be accompanied by a copy of the doctor's prescription.

4.Fill in this claim form carefully, print, sign, and send it within maximum 90 days of treatment to:

Swiss Global Insurance

claims@swissglobalinsurance.com

Section A – Insured Member

1. Family Name: _____ 2. First Name: _____

3. Member ID Number: _____ 4. Date of Birth: _____

5. Telephone N°: _____ 6. E-mail: _____

7. Mailing Address: _____

Country: _____ Zip/Post Code: _____

*If your bank account changed recently, please attach an account identification form and specify currency:*_____

Section B - Patients listed on this claim form

	1. Full Name	2. Relationship (Spouse or Child)
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____

Please complete in block letters and answer reverse side

Section C - Services / Supplies (Use one line for each health care bill)

	Date of Services (Day/month/year)	First Name of Patient	Description of Medical/Dental Services, Procedures, or Supplies	Diagnosis or Cause For Medical Service	Charges & Currency	Doctor or Location of Service
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____

If any of the above is a result of an accident, please specify: ☐ Automobile ☐ Work-Related ☐ Other

A. Circumstances of accident:

B. Date and place of accident:

C. N° of bills above related to accident (*example* 1, 3, 6):

Section D – Signature

I hereby certify that the information provided is correct and true to the best of my knowledge.

Signature of Patient: Date: