Golden Care® Declaration Form

YOUR HEALTH INSURANCE AROUND THE WORLD

REIMBURSEMENT, DIRECT SETTLEMENT OR PRIOR AGREEMENT

A GENERAL INFORMATION

1 • The patient

a - Name, first name : ....

b - Date of birth : |_|_| |_|_| |_|_|_|_|

c - Insured number (on the card) : |_|_|_|_|_|_|_|

2 • Correspondence information (please specify the country and the city code)

a - Postal address : ....

Zip/City : .... Country : ....

b - Contact number: Tel. 1 : .... Tel. 2 : .... Fax : ....

c - E-mail : ....

3 • Does this claim concern a follow-up treatment of an affection already declared to Golden Care ?

☐ Yes N° : .... ☐ No

4 • Do you have any other insurance policy covering the medical costs for this claim ? ☐ Yes ☐ No

If yes, please include the original detailed account of settlements already made and copies of the prescriptions, bills and other relevant supporting documents.

B MEDICAL INFORMATION

1 • In case of accident

a - Date of accident : |_|_| |_|_| |_|_|_|_|

b - Place of accident : ....

c - Nature of injuries : ....

....

d - Exact circumstances of the accident : ....

....

....

e - Is a third involved ? : ☐ Yes ☐ No

Name and first name : ....

Address : ....

Zip/City : .... Country : .... Tel. : ....

f - At the time of the accident, were you officially employed : ☐ Yes ☐ No

Name and address of your employer : ....

g - Was there any official police registration of the accident : ☐ Yes ☐ No .... Please join a copy.

2 • In case of illness

a - Date of the first symptoms : |_|_| |_|_| |_|_|_|_|

b - Nature of illness : ....

c - Have you already been treated (including prescribed medicines) for this condition or any related condition prior to your subscription to the Plan :

☐ Yes ☐ No If yes, please specify : Date of the treatment : |_|_| |_|_| |_|_|_|_|

Treatment: ....

....

Physician name : .... Address : ....

Zip/City : .... Country : .... Tel. : ....

Fax : .... E-mail : ....

3 • In the event of dental treatment (if you have this option)

a - Does this treatment concern : ☐ Routine dental treatment ☐ Dental prosthesis

b - Is your dental treatment following an accident: ☐ Yes ☐ No

c - Have you already received any treatment in relation with this even ? : ☐ Yes ☐ No

If yes, please specify : Date of the treatment : |_|_| |_|_| |_|_|_|_|

Treatment : ....

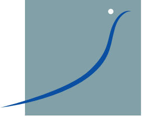
4 • In the event of maternity (if you have this option)

a - Date of your last menstruation : |_|_| |_|_| |_|_|_|_|

b - Expected date of delivery : |_|_| |_|_| |_|_|_|_|

c - Expected place of delivery : ....

FormDecGLOBALGB-2018



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C YOUR CLAIM

1 • Reimbursement

a - In which currency would you like to be reimbursed (if you have this option): ☐ CHF ☐ EUR ☐ USD

b - Modality of reimbursement:

☐ Credit transfer:

Name of the bank: ....

Address: ....

Zip/City: .... Country: ....

Account number: .... Bank sort code/Clearing: ....

Iban: .... Bic/Swift: ....

2 • Direct settlement (direct settlement may only be given to a hospital or maternity ward, in event of hospitalization or delivery)

a - Physician name: ....

Address: ....

Zip/City: .... Country: ....

Tel.: .... Fax: .... E-mail: ....

b - Name of the hospital: ....

Address: ....

Zip/City: .... Country: ....

Tel. 1: .... Tel. 2: .... Fax: ....

c - Date of admission: |_|_| |_|_| |_|_|_|_|

d - Scheduled length of stay: ....

3 • Prior approval (prior approval is compulsory for the reimbursement of certain pathologies and/or services as mentioned in the General Conditions of your contract)

a - Treatment concerned: ....

b - Physician having ordered necessary treatment: ....

Address: ....

Zip/City: .... Country: ....

Tel.: .... Fax: .... E-mail: ....

Please include:

- ☐ the medical record sign by the physician.
- ☐ the original of all prescription and bills signed by the physician.
- ☐ bank account details.
- ☐ the original detailed account of the settlement made by any other insurance.
- ☐ all original and relevant supporting documents.

In case of accident please include:

- ☐ all originals and supporting documents.

In case of prior approval:

- ☐ copy of your physician's prescription.

Declaration: I hereby authorise the release of any medical information necessary for the handling of my claim. I declare the above information as accurate and complete to the best of my knowledge.

Date: |_|_| |_|_| |_|_|_|_|

Signature of Insured or legal representative

....

Send your claim to:
Golden Care – Medical Service
31 Boulevard Helvétique - 1207 Geneva - Switzerland

Golden Care SA - Centre de gestion et d'administration médicale et d'assistance
31 boulevard Helvétique – 1207 Geneva, Switzerland – Tel.: +41 22 786 12 00 – Fax: +41 22 786 12 20
E-mail: goldencare@goldencare.ch – Web: www.goldencare.ch

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