eurosure
INSURANCE COMPANY LTD

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CLAIM FORM
MEDICAL INSURANCE

Policyholder's Name | Policy No.

Patient's Name | Date of Birth | Date of Insurance

PART 1. PHYSICIAN'S DECLARATION - To be completed by the Physician

I, the undersigned Physician specialised in ____ examined the Patient

____ and diagnosed the condition of ____

Physician's Name | Telephone | Date of Examination | Physician's Signature

PART 2. PRESCRIBDED MEDICATION - To be completed by the Physician

Please attach the relevant receipt of payment.

PART 3. LABORATORY TESTS - To be completed by the Physician

Please attach the relevant receipt or payment and test results.

PART 4. X-RAYS - To be completed by the Physician

Please attach the relevant receipt of payment, the x-rays or MRI or ULTRA SOUND and the corresponding medical results.

CLAIM DECLARATION - To be completed by the Policyholder and the Patient

Policyholder's Name | Policy No.

Patient's Name

Date of Birth | Relationship | Date of Insurance

CONDITION – Diagnosis

(In the instance of an accident where bodily injuries have been sustained, state the location and details of the accident)

Date of first appearance of symptoms relating to the illness

Have you ever suffered from the same cause in the past? If Yes, when?

Physician's Name | Date of Examination

I hereby declare that all information contained in this form is true, accurate and complete. At the stage of claiming compensation, I agree to provide the Company EUROSURE INSURANCE COMPANY LTD with the results of my medical and diagnostic examinations and treatments as proof and for evaluation by physicians affiliated with the Company, subject to the provisions of the General Data Protection Regulation (EU) 2016/679, as amended, only such data which is completely relevant and necessary for the purpose of examining my claim in the event where the Company considers that this is strictly necessary in order to decide whether to pay compensation to myself under the terms of my insurance policy and/or to determine the amount compensation.

I further authorise all physicians and/or other persons who have treated me and all hospitals or other institutions or insurance companies, to provide complete information in relation to the present claim, if requested by the Company.

Date | Patient's Signature | Date | Policyholder's Signature