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. Then take the precaution of making photocopies of all documents before sending the originals to SGI.
2. Answer all questions on both sides of the claim form and attach to it the originals of all reimbursable bills. Bills should indicate name and date of birth of patient, date of treatment, a detailed description of medical services and the amount of charges corresponding to each category of treatment or service. Pharmacy bills should identify drugs purchased (name and cost per item). Bills must specify name and address of medical provider or pharmacy. Cash receipts which do not provide this information are not acceptable.
3. A bill 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. The claim form must be completed and sent by mail or email to SGI International Services along with original invoices and payment receipts as well as other relevant document justifying your request.
   Please follow the instructions on the form.
5. Fill in this claim form carefully, print it, sign it, and mail it within twelve months of treatment to:

Swiss Global Insurance
c/o Swiss Health International
Rue du Rhône 14
CH-1204 Geneva, Switzerland
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. ________________	a. ________________
b. ________________	b. ________________
c. ________________	c. ________________
d. ________________	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: