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International Health Care Claim Form

Section A • Employee

Name	First Name	Date of Birth	ID Number
Postal address			
Zip Code	City	Country	
Telephone	Fax	E-mail	Employer

Payment method: Cheque Bank Transfer / Currency: _____ (If your account changed recently, please provide details).

Section B • Patient(s) listed on this claim form

Full Name	Relationship to Insured	Coverage by Social Security or other plan
		<input type="checkbox"/> No <input type="checkbox"/> yes, please specify:
		<input type="checkbox"/> No <input type="checkbox"/> yes, please specify:
		<input type="checkbox"/> No <input type="checkbox"/> yes, please specify:
		<input type="checkbox"/> No <input type="checkbox"/> yes, please specify:

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

Date of services	First Name of Patient	Description of Medical / Dental Services, Procedures or Supplies	Diagnosis or Cause for Medical Service	Charges & Currency	Practitioner / Facility
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

If any of the bills is a result of an accident, please specify:

Transport

Work-Related

Other

Circumstances of accident

N° of bills related to accident (example 2, 5, 6)

Date and place of accident

Section D • Signature

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

Date

Signature of Employee

Section E • Physician or provider (this section must be completed by the physician for all treatment exceeding US\$ 400 or € 400)

Is the cause an accident?

Yes No

If yes, please specify:

A transport accident

A work-related accident

Other

Diagnosis of illness / injury

History of this condition with dates on which you administered previous treatment

Description of services / of prescribed treatment

Name of Physician / telephone / fax

Stamp / Date / Signature

Procedure for filing a claim

1. If you, your spouse or children are covered by French Social Security (or another government plan) or another group insurance policy, you must obtain the reimbursement to which you are entitled before filling out this claim form. In this case enclose with your claim a copy of all medical and dental bills relating to the claim, **as well as the original statement of Social Security or another insurance provider**. Employees covered by the Caisse des Français de l'Étranger (CFE) have to use CFE's claim forms instead of this one. CFE's claim forms are available on www.cfe.fr. In order to facilitate the administration of your policy, we coordinate payments with the CFE. Please send us the entire claim (CFE's claim form and related original bills) and we will make one payment (including both CFE's and our parts).

2. Answer all questions on both sides of the claim form and mail it to us within 12 months of treatment. Attach to it **the original of all reimbursable bills, prescriptions and Doctors' fees**. Bills should indicate that they are paid in full as well as show the name and date of birth of patient, the date of treatment, a detailed description of medical services and the amount of charges corresponding to each category of treatment or service. Bills must specify name and address of medical provider or pharmacy. Cash receipts which do not provide this information are not acceptable. **For care in France**, ask practitioners to provide you with the "feuille de soins de la Sécurité Sociale" and stick the "vignettes" (which you will find on the packaging) on the pharmacy bills.
3. For series of treatment, the prescription must clearly indicate the length of treatment or the number of sessions required

- and a copy of the prescription must be enclosed in each claim. Prescriptions are valid only for 6 months.
4. If a treatment costs more than US\$ 400 or € 400, you must have the physician complete and sign section E of this claim form.
5. 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 us **the originals**.

**Mail your claims
to your nearest Claim Department
(see addresses on the other side).**