Medical Expenses and/or Emergency Expenses Abroad Notification

Kindly fill in and send to

O.F. Gollcher & Sons Ltd
Mailing/Office Address: 19 Zachary Street, Valletta VLT 1133
e-mail: claims@gollcher.com, tel: +356 25691500, fax: +356 21234195

attaching the following

- **Original receipts for the expenses for medical treatment**
- **Original receipts for purchase of medicine**
- **Prescriptions/copies of prescriptions**
- **Name and contact information of your doctor and dentist in home country**

Policy Holder	Full Name: ______________________________________ Phone:_______________________________ Address: ____ E-mail.: ______________________________ Postal Code/City ____ Date of Birth:_________________________ Policy no:. ____ ___________
Insurance period	From:_______/___________ Till:________/____________
Description of Incident	**Illness / Accident** When and where did the illness occur? Date: ______/______ Place: _________________ When and where did the accident happen? Date: ______/______ Place: _________________________ If the accident happened during sport activities, please state the type of activity: ____
	Please, describe why and how you visited the doctor/hospital + give a specification of the costs ____ ______________________ ____ ______________________ ____ ______________________ ____ ______________________ ____ ______________________ ____ ______________________ ____ ______________________

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Description of Incident	State diagnosis and the name of the doctor ______________________________ ______________________________ ______________________________ Did you receive treatment for this illness prior to leaving your country of residence? Yes: _ No:_

Further information about accident / crime	Witness to the accident: Name:______________________ Address:______________________
Description of Incident	**Other** What is your reason for submitting this claim? ______________________________ ______________________________ ______________________________ ______________________________ When and where did the event occur? Date: ______/______ Place: ________________
	Please, give a specification of the costs made ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________

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Other insurance	Do you have any other insurance that may cover this claim?: Yes:_ No:_ If yes: Company:____ Policy No.:_____________________________________ Have you filed a claim with the above mentioned company? Yes:_ No:_
Signature	I/We hereby declare that the above information and statements are, to the best of my/our knowledge and belief, correct and complete. I/we also hereby agree to give O. F. Gollcher and Sons Ltd. consent to share information contained herein with other insurance companies and third parties in order to verify the information and statements made herein. Furthermore, I/we grant permission for O.F. Gollcher & Sons Ltd to review my medical records. _______________________________________ ______/______________2014 Signature Date