MEDICAL EXPENSES CLAIM FORM

File N°	

1. Insured's information

Name		First Name	
Address			
Postcode		City	
Telephone Nr		Mobile	
E-mail			

2. Information on Health Insurances

Name of your primary Health Insurance(s)	
Address	
Police Nr	

Did you applied for claims in this Insurance Company? ☐ Yes ☐ No

Did you receive any allowance for this incident? ☐ Yes ☐ No

Amount of this allowance/

If yes please join the proof of the allowance / If you had a refusal please join the copy of it

☐ I don't have any health insurance

3. Indications about the claim

Reason of the consultation ☐ illness ☐ accident ☐ dentist

Description

TSM Compagnie d'Assurances
Société coopérative
Cours de Rive 2
CH – 1204 Genève
info@tsm-assistance.com
Tél +41 (0)22 819 44 00
Fax +41 (0)22 819 44 99
www.tsm.ch

4. Indications about the patient

Name	
First Name	
Date of birth	

5. Travel Details

Travel destination				
Dates of trip	from		to	
Itinerary	from		to	

6. Your reimbursement request

I hereby join the supporting documents for the reimbursement of

Service description	Date of service	Amount	Currency

I wish a reimbursement in the following currency/

Kindly be advised that, the OANDA Currency Converter rate will be used as a reference.

Should you have paid your medical treatment with your credit card, we could process your reimbursement based on your credit card's statement.

Please note this exception can only be accepted if you submit those documents together with your claim form.

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7. Bank Details where reimbursement should be paid

Exact name of account holder (as registered in bank)

Exact adress of account holder (as registered in bank)

Name and adress of the bank

IBAN (mandatory if existing in the account country)

BIC Swift code

Account Number (only if the IBAN doesn't exist in the account country)

8. Documents that must be included are detailed below. Failure to provide full documentation as detailed below may jeopardise your claim

☐ Full Medical Report

☐ Original Invoice(s)

☐ Copy of the Statement of Health insurance benefits

9. Declaration: I declare that the above statements are true and complete to the best of my knowledge and belief. I am fully aware that my insurance rights can be cancelled if the data I declared are false, incomplete or contradictory, even if it bears no prejudice to the insurer. I clearly authorize TSM Insurance Company to request or transmit if necessary to third parties any useful information for the handling of the claim (Doctors, Insurance companies, etc...)

Date, Place Signature