Genikes Insurance

CLAIM FORM HOSPITALIZATION

Policy No: ....

CONTRACTING PARTY / INSURED PERSON

Name: .... ID No. ....

Address: ....

Telephone No. .... Fax No. ....

E-mail address:..

PATIENT

Name: .... ID No:...

Address: .... Tel. No:...

THE INCIDENT

Date and time: ....

Circumstances of the accident or disease:

....

....

....

DETAILS OF BODILY INJURY or DISEASE

(*Attach medical reports*)

....

....

....

....

Name of hospital and treating doctor:

....

Medical treatment offered:

....

Genikes Insurance

DESCRIPTION AND AMOUNT OF CLAIM

(Attach receipts, invoices or/and other supporting documents)

1...

2 ....

3...

4 ....

5 ....

6 ....

TOTAL AMOUNT OF CLAIM : € ....

Date ....

SOLEMN DECLARATION

I/WE solemnly declare that all information given above is true and accurate.

Signature of Contracting Party / Insured

………………………………………………………………………….

IMPORTANT NOTICE:

Receipt of this Form by the Company does not constitute an admission of liability under the Policy.

Data Protection – Privacy Notice

We collect and use personal information about you so that we can process your claim under your Policy. For more information on how we use your personal information and your rights, please refer to our Privacy Notice at www.genikesinsurance.com.cy. If you do not have access to the internet, please contact us and we will send you a printed copy.