# Medical Expenses and/or Emergency Expenses Abroad Notification

Kindly fill in and send to


**O.F. Gollcher & Sons Ltd**
**Mailing Address: P.O. Box 268, Valletta VLT 1000, 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**

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|---|---|
| **Policy Holder** | Full Name: _____ Phone:_____<br>Address: _____ E-mail.: _____<br>Postal Code/City _____ Date of Birth:_____<br>Policy no:. _____ |
| **Insurance period** | From:_____/_____ Till:_____/_____ |
| **Description of Incident** | **Illness / Accident**<br>When and where did the illness occur?<br>Date: _____/_____<br>Place: _____<br>When and where did the accident happen?<br>Date: _____/_____<br>Place: _____<br>If the accident happened during sport activities, please state the type of activity:<br>_____ |
| | Please, describe why and how you visited the doctor/hospital + give a specification of the costs<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |

# Medical Expenses and/or Emergency Expenses Abroad Notification cont'd.

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| **Description of Incident** | State diagnosis and the name of the doctor<br>_____<br>_____<br>_____<br>Did you receive treatment for this illness prior to leaving your country of residence? Yes: _ No:_ |

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| **Further information about accident / crime** | Witness to the accident: Name:_____<br>Address:_____ |

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| **Description of Incident** | **Other**<br>What is your reason for submitting this claim?<br>_____<br>_____<br>_____<br>_____<br>When and where did the event occur?<br>Date: _____/_____<br>Place: _____ |
| | Please, give a specification of the costs made<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |

# Medical Expenses and/or Emergency Expenses Abroad Notification cont'd.

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| **Other insurance** | Do you have any other insurance that may cover this claim?: Yes:_ No:_<br><br>If yes:<br><br>Company:_____ Policy No.:_____<br><br>Have you filed a claim with the above mentioned company? Yes:_ No:_ |

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| **Signature** | I hereby declare that the information given is true and correct.<br>Furthermore, I grant permission for O.F. Gollcher & Sons Ltd to review my medical records.<br><br>_____ _____/_____200___<br>Signature Date |