

MEDICAL CLAIM NOTIFICATION FORM

Please complete this form in block letters (English/Dutch/French/German), keep a copy and post it to SCI Insurance (address below) within 48 hours after medical consultation.

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|---|---|---------------------------|
| INFORMATION ABOUT THE INSURED | FULL NAME | |
| | DATE OF BIRTH | |
| | NATIONALITY | |
| | HOME ADDRESS | |
| | EMAIL ADDRESS | |
| INFORMATION ABOUT THE PROJECT | NAME & LOCATION | |
| | NAME, EMAIL, ADDRESS OF COORDINATOR | |
| | SCI BRANCH / NATIONAL ORGANISATION | |
| START AND END OF INSURANCE PERIOD | FROM: | |
| | TO: | |
| OTHER INSURANCE | IS THE INSURED COVERED BY ANOTHER INSURANCE ? YES / NO | |
| | NAME, ADDRESS & POLICY NO AT THE OTHER INSURANCE | |
| | WHAT DOES THE OTHER INSURANCE COVER YOU FOR ? | |
| | HAVE YOU PLACED A CLAIM WITH THE OTHER INSURANCE ? YES, ON: NO BECAUSE: | |
| DESCRIBE WHAT HAS HAPPENED / HOW THE ILLNESS DEVELOPED: | | |
| NAME AND ADDRESS OF WITNESS(ES): | | |
| DATE AND PLACE: | SIGNATURE OF INSURED: | SIGNATURE OF COORDINATOR: |

EMERGENCY PHONE:

00.32.3.2265727 (International Secretariat) or 00.32.484.108138 (Ossi Lemström)

MEDICAL REPORT for SCI INSURANCE

PLEASE ASK THE MEDICAL DOCTOR TO FILL IN THIS PAGE OF THE FORM

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|--|------------------------------------|-----------------------------|-----------------|
| INITIAL CONSULTATION | | PLACE | |
| | | DATE AND TIME | |
| INJURY | INDICATE NATURE & PLACE OF INJURY: | | |
| | | | |
| | NEUROLOGICAL DAMAGE : | | |
| | INTERNAL INJURIES : | | |
| ILLNESS | SYMPTOMS: | | |
| | RELEVANT MEDICAL HISTORY: | | |
| RESEARCH | TEMPERATURE: | | PULSE: |
| | RESPIRATION: | | BLOOD PRESSURE: |
| | URINE ANALYSIS: | | X RAY ANALYSIS: |
| DIAGNOSIS | FINAL / PROVISIONAL: | | |
| COULD THE INJURY/ILLNESS BE PARTLY OR ENTIRELY DUE TO PREVIOUS ILLNESS OR ACCIDENT ? YES / NO, BECAUSE: | | | |
| IS THE PATIENT UNABLE TO WORK ? YES / NO, FROM: TO: | | | |
| WILL THERE BE ANY LONG TERM IMPAIRMENT / DISABILITY ? YES / NO, DETAILS: | | | |
| ARE THERE ANY PRE-EXISTING CONDITIONS THAT MAY IMPAIR RECOVERY ? YES / NO, DETAILS: | | | |
| INITIAL TREATMENT: | | FURTHER TREATMENT REQUIRED: | |
| DOCTOR'S NAME & ADDRESS: | | OFFICIAL STAMP | |
| DOCTOR'S SIGNATURE: | | | |