ERV, CLAIMS DEPARTMENT, P.O. BOX, CH-4002 BASEL
TEL. +41 58 275 27 27, CLAIMS@ERV.CH, WWW.ERV.CH

Claim reports

Claim-No.

Medical and hospital costs ILLNESS

Dear Customer,

in order to be able to provide you with insurance benefits quickly and straightforwardly, we require some important information from you. Please complete this notice of loss carefully and enclose the following documents, if applicable:

- ☐ Original receipts with prescriptions
- ☐ Original invoices (physician, hospital)
- ☐ Copy of the insurance policy

Should you be unable to answer a question in whole or in part, please state the reasons therefor.

Questions regarding the policyholder (person who took out the insurance)

Name:

First given name: Date of birth:

Raod/House number:

Post code/Place:

Phone (reachable during the day): E-mail adress:

Account number (IBAN):

Bank code (BIC/SWIFT):

Name, post code and place of the bank

Questions regarding the insured person

Name First given name:

Date of birth: Nationality:

Questions regarding health insurance

1. Date the insurance contract was concluded:
2. Policy No.:
3. Are other insurance policies in place for this event? ☐ Yes ☐ No
4. If so, please state
5. 5. Was an indemnity paid or applied for elsewhere? ☐ Yes ☐ No
6. If so, state name

Questions regarding the illness

7. Type of illness (please state the exact designation of the illness:

8. Is it an aggravation of a chronic illness? ☐ Yes ☐ No
9. Is it an aggravation of a pre-existing condition? ☐ Yes ☐ No

10. If so, was the illness treated before? ☐ Yes ☐ No

11. If so, please state the name of the physician. Name and address:

12. Is it an acute illness? ☐ Yes ☐ No

13. Since when have you had this medical condition? Date:

14. When did you consult a physician for the fist time? Date:

15. Was the treatment completed? ☐ Yes ☐ No

16. If not, expected duration of treatment (end date):

17. Are additional invoices to be expected? ☐ Yes ☐ No

18. If so, state name. Name and address:

ERV shall be exempt from its obligation to pay if after occurrence of the insured loss, the insured person attempts to fraudulently misrepresent to ERV the circumstances that are significant for the cause and the amount of the benefits.

I authorise doctors, hospitals and insurances of all kinds of providing ERV with all required information and hereby release the above from their statutory confidentiality obligations.

Place and date

Signature of the damage originator or the statutory representative