vanbreda INTERNATIONAL

United Nations
Nations Unies

Group medical, hospital and dental Scheme
Claim for reimbursement of expenses

See **instructions** on reverse side before completing this form.

VANBREDA REFERENCE NUMBER 001/

AND/OR UN HQ INDEX NR

To be completed by the claimant

1. SUBSCRIBER'S NAME AND FIRST NAME:

2. ADMINISTERING OFFICE OR ORGANISATION — DUTY STATION (CITY, COUNTRY)

3. CORRESPONDENCE ADDRESS :

4. E-MAIL ADDRESS

5. NAME OF PATIENT

6. DATE OF BIRTH (D/M/Y) ___ / ___ / _____ **7.** SEX OF PATIENT ☐ FEMALE ☐ MALE

8. RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ UNMARRIED DEPENDENT CHILD

9. IS PATIENT COVERED UNDER AFTER-SERVICE HEALTH INSURANCE ARRANGEMENTS? ☐ YES ☐ NO

IF YES, PLEASE INDICATE PLACE OF RESIDENCE :

10. TOTAL AMOUNT CLAIMED PER CURRENCY

CURRENCY	AMOUNT	NR OF ATTACHMENTS

11. IN CASE OF ACCIDENT : IS THERE A THIRD PARTY INVOLVED ? ☐ YES ☐ NO

12. WAS ILLNESS OR INJURY RELATED TO EMPLOYMENT ? ☐ YES ☐ NO

13. IS THE CLAIM REIMBURSABLE BY ANOTHER INSURANCE ? ☐ YES ☐ NO

14. REIMBURSEMENT TO BE MADE BY (PLEASE INDICATE YOUR PREFERRED MODE OF PAYMENT) :

☐ ELECTRONIC TRANSFER TO THE BANK ☐ CHEQUE

FULL ACCOUNT NUMBER — NAME OF BENEFICIARY

NAME OF ACCOUNTHOLDER

NAME OF BANK — ADDRESS OF BENEFICIARY

FULL ADDRESS OF BANK:

BANK IDENTIFICATION CODE : IBAN CODE

SWIFT OR ABA CODE

15. I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT AND THAT I WAS ENROLLED IN THE U.N. MEDICAL, HOSPITAL AND DENTAL SCHEME FOR THE PERIOD FOR WHICH THESE EXPENSES WERE INCURRED.

DATE :

SIGNATURE OF CLAIMANT

Important information
In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my special permission regarding the processing of the medical data concerning myself and/or the members of my family (article 7 of the Belgian law of December 8, 1992 concerning the private life).

To be completed by the Resident Representative or the Administrative Officer

16. I CERTIFY THAT THE STAFF MEMBER WAS EMPLOYED BY THE U.N. AT THE TIME OF THE ILLNESS OR TREATMENT COVERED BY THIS CLAIM.

DATE :

SIGNATURE RESIDENT REPRESENTATIVE OR ADMINISTRATIVE OFFICER

594702 / 5.46.827 (1203)

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Vanbreda Reference number 001/

And/or UN HQ Index nr

To be completed by the claimant

1. Subscriber's name and first name:

2. Administering Office or Organisation — Duty station (City, Country)

3. Correspondence address :

4. E-mail address

5. Name of patient

6. Date of birth (d/m/y) ___ /___ /_____ **7.** Sex of patient ☐ Female ☐ Male

8. Relationship of patient to subscriber ☐ Self ☐ Spouse ☐ Unmarried dependent child

9. Is patient covered under after-service health insurance arrangements? ☐ Yes ☐ No

If yes, please indicate place of residence :

10. Total amount claimed per currency

Currency	Amount	Nr of attachments

11. In case of accident : Is there a third party involved ? ☐ Yes ☐ No

12. Was illness or injury related to employment ? ☐ Yes ☐ No

13. Is the claim reimbursable by another insurance ? ☐ Yes ☐ No

14. Reimbursement to be made by (please indicate your preferred mode of payment) :

☐ Electronic transfer to the bank ☐ Cheque

Full account number — name of beneficiary

Name of accountholder

Name of bank — Address of beneficiary

Full address of bank:

Bank Identification Code : IBAN Code

SWIFT or ABA Code

15. I certify that the above statements are correct and that I was enrolled in the U.N. Medical, Hospital and Dental Scheme for the period for which these expenses were incurred.

Date :

Signature of claimant

Important information
In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my special permission regarding the processing of the medical data concerning myself and/or the members of my family (article 7 of the Belgian law of December 8, 1992 concerning the private life).

To be completed by the Resident Representative or the Administrative Officer

16. I certify that the staff member was employed by the U.N. at the time of the illness or treatment covered by this claim.

Date :

Signature resident representative or Administrative Officer

594702 / 5.46 827 (1203)

How to submit claims

Please use your Vanbreda reference number (which you can find on any previously received settlement note or on your membership card) and/or your UN HQ index number.

The following information refers to the numbered items on the front side of the claim form

1. Please write your name, last name first followed by your first name.

3. Please clearly indicate your correspondence address as this is used to send you our settlement details, and cheque.

5. Please submit a separate claim for each person.

9. If the patient is covered under the after-service health insurance arrangements, items 2 and 12 should not be completed. For after-service health insurance coverage, no certification is required below claimant's signature. (item 16)

10. Please add all your expenses together per currency.
Only one amount per currency is necessary.
Indicate the number of attachments for each currency.
Make sure that:
- the dates and amounts of expenses are mentioned on each bill.
- the diagnosis is indicated in an attachment to this form (in a sealed envelop) and ensure that all documents, original receipted bills, and medical prescriptions or receipts for medical prescriptions are attached.
- a summary translation in English, French, Spanish, Italian, German or Dutch for bills written in languages other than the foregoing should be provided.

14. After the claims processing by Vanbreda International, reimbursement will be effected (in United States dollars only) by means of a cheque or an electronic bank transfer. Please indicate the mode of payment you prefer:
- In case you opt for reimbursement by electronic bank transfer, it is essential that you provide us with complete bank information: full account number, name of the accountholder, name and full address of the bank, SWIFT code or IBAN code (the latter only for payment within the European Union). For Italy, ABI and CAB code are required. If you do not provide us with complete information, a cheque will be sent to your correspondence address.
- In case you opt for reimbursement by cheque, a cheque-letter mentioning the detail of the reimbursement is sent to the address you indicate.

A settlement note will always be forwarded to your correspondence address.

15. Claim has to be signed and dated by the claimant.

16. Please check that the Resident Representative or Administrative Officer has signed the claim (except for after-service health insurance subscribers).

Original claim should be sent to :

Vanbreda International
Plantin en Moretuslei 299
2140 Antwerpen - Belgium

or

P.O.Box 69
2140 Antwerpen - Belgium

Attention! You can also print the electronic version of this form from your personal webpages (www.vanbreda-international.be). This form will carry your name, Vanbreda reference number and personalized barcode.