global health

Claim form Foyer Global Health

Your personal details

Full name of policyholder

Date of birth

Global Health policy number

Telephone

Email

Full name of patient

Date of birth

Has confirmation of coverage been sent? Yes No

Patient Name	Name & Address of the Hospital or treating doctor	Treatment Date	Description of Service	Amount	Currency

Elective? Yes No Emergency? Yes No Date

In case of an accident, please indicate how it occurred

Please provide full details of the medical condition requiring treatment, including the ICD code 9 or 10
(International Classification of Disease, if possible)

Has treatment been received for a similar illness before? Yes No
Please indicate first date

Do you hold another health insurance policy? Yes No
If yes, which one?

I hereby certify that to the best of my knowledge this claim form does not contain any false, misleading or incomplete information. I understand and accept that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for legal action. In respect of any medical claim, I hereby authorise my general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Foyer Global Health. or their appointed representatives. If a minor was treated, a parent or guardian should sign this section.